POLICY AND PROCEDURE

Title: California Charity Care Procedure

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Scope:
The purpose of this policy is to outline the circumstances under which charity care and payment discounts may be provided to qualifying low-income patients for medically necessary services provided.

Purpose:
Corona Regional Medical Center (CRMC) recognizes that there are individuals in need of medical services who are unable to pay for such services separate from patients unwilling to pay for services. It is the intent of CRMC to assist such patients with the settlement of their portion of the medical bill by property screening for Charity Care, Discounted Payment if unable to pay the bill and to make services available at no cost or a reduced cost to individuals who meet the eligibility requirements.

1. CRMC will comply with federal and state laws and regulations relating to emergency medical services and charity care.
2. CRMC will provide charity care to qualifying patients with no other primary payment sources to relieve them of all or some of their financial obligation for medically necessary CRMC services.
3. In extenuating circumstances, the hospital may at its discretion approve charity care outside of the scope of this policy.
4. This policy is to be interpreted and implemented so as to be in full compliance with California Assembly Bill 774, codified at Health and Safety Code Section 127400 et. seq., effective January 1, 2007, as revised by California State Senate Bill 350, effective January 1, 2008, Assembly Bill 1503 effective January 1, 2011, SB 1276 effective 01/01/2015, Assembly Bill 1020 effective January 1, 2022. All collection agencies working on behalf of CRMC shall comply with Health and Safety Code Section 127400 et. seq. as amended and applicable CRMC policies regarding collection agencies.

Definitions:

- "Charity Care" refers to full financial assistance to qualifying patients, to relieve them of their financial obligation in whole for medically necessary health care services (full charity).

- "Discount Payment" refers to partial financial assistance to qualifying patients, to relieve them of their financial obligation in part for medically necessary health care services (partial charity).

- "Self-pay patient" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital. Self-pay patients may include charity care patients.

- "Private Pay Discount" is a discount provided to patients who do not qualify for financial assistance and who do not have a third-party insurance carrier or whose insurance does not cover the service provided or who have exhausted their benefits. See Uninsured Discount Policy.

Eligibility for Charity shall be determined by an inability to pay defined in this policy based on one or more of the following criteria:

A. Presumptive Charity — Individual assessment determines that Financial Assistance Application is not required because:
   i. Patient is without a residence address (ex. homeless).
   ii. Services deemed eligible under this policy but not covered by a third-party insurance carrier were rendered to a patient who is enrolled in some form of Medicaid (Medi-Cal for California residents) or State Indigent Program (e.g., receiving services outside of Restricted Medi-Cal coverage).
   iii. Annual out-of-pocket costs:
      a. Incurred by the individual at the hospital that exceed 10 percent of the patient's family income in the prior 12 months.
      b. 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.
         1. "Patient's family" means the following:
            a) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not.
            b) For persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative
   iv. Services were denied treatment authorization, as financial qualification for these programs includes having no more than marginal assets and a Medicaid defined share of cost as the maximum ability to pay; and/or
      a. Patient's inability to pay is identified via an outside collection agency income/asset search.
      b. Patient's inability to pay is identified by CRMC staff through an income/asset search using a third-party entity.
      c. Patient is deceased

B. Charity — Individual assessment of inability to pay requires one or more of the following:

i. Completion of a Financial Questionnaire.
ii. Validation that a patient's gross income is less than 400% the Federal Poverty Guidelines (FPG) applicable at the time the patient has applied for financial assistance. A patient with this income level will be deemed eligible for 100% charity care: and/or
iii. Validation that a patient's gross income exceeds 400% of the FPG applicable at the time the patient has applied for financial assistance and that their individual financial situation (medical debt load, etc.) makes them eligible for possible discount payment (partial charity care) or 100% charity care. However, patients with gross income less than 500% of FPG will never owe more than 100% of the applicable Medicare allowable amount for the hospital where treatment was received. This amount shall be verified at least annually. A patient with a gross income exceeding 500% of FPG will owe no more than the applicable private pay inpatient or outpatient discounted reimbursement rate, or stated co-pay amount, whichever is less. In addition, uninsured and insured patients with gross incomes less than 500% of FPG who incur total medical expenses in excess of ten percent (10%) of gross annual income during the prior 12 months will receive 100% charity benefit. Eligible costs for charity write off shall include only the patient liability amounts after insurance is billed and insurance liability amounts collected. Further, qualified retirement plan and deferred compensation, monetary assets may not be considered in determining an ability to pay and the first $10, 000 of other monetary assets and 50% of the remaining monetary assets must not be used in the evaluation for financial assistance.

Charity Care is not:

- Considered to be a substitute for personal responsibility.
- Patients are expected to cooperate with CRMC procedures for obtaining charity or other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay (as outlined). Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets
- Bad Debt: A bad debt results from a patient’s unwillingness to pay or services for which hospitals anticipated but did not receive payment.
- Insurance Denials: where the CRMC was unable to obtain payment due to untimely billing per contractual terms; or retroactive denial of service by a managed care insurance carrier where appeal is not successful.
- Contractual adjustment: The difference between the retail charges for services and the amount allowed by a governmental or contracted managed care insurance carrier for covered services that is written off.

Evaluation Process:

- CRMC shall display information about its charity care policy at appropriate access areas.
- A person seeking charity care will be given a preliminary screening and if this screening does not disqualify him/her for charity care, an application will be provided with instructions on how to apply.
- As part of this screening process CRMC will review whether the guarantor has exhausted or is not eligible for any third-party payment sources.

  - Where the guarantor's determined an indigent person (homeless) is obvious to CRMC, then a prima-facie determination of eligibility may be made and, in these cases, CRMC may not require an application or supporting documentation.
- A patient (guarantor) who may be eligible to apply for charity care after the initial screening will be given fourteen (14) days to provide sufficient documentation to CRMC to support a charity determination.
- Based upon documentation provided with the charity application, CRMC will determine if additional information is required, or whether a charity determination can be made.
- The failure of a guarantor to reasonably complete appropriate application procedures shall be sufficient grounds for CRMC to initiate collection efforts.
- An initial determination of sponsorship status and potential eligibility for charity care will be completed as closely as possible to the date of service.
- CRMC will notify the patient (guarantor) of a final determination within fifteen (15) business days of receiving the necessary documentation.
- The patient (guarantor) has the right to appeal the determination of ineligibility for charity care by providing relevant additional documentation to CRMC within thirty (30) days of receipt of the notice of denial.
- All appeals will be reviewed and if the determination on appeal affirms the denial, written notification will be sent to the patient (guarantor) and the Department of Health in accordance with state law. The final appeal process will conclude within thirty (30) days of the receipt of a denial by the applicant.

PROCEDURE:

Communication and Notification of the availability of financial assistance within the community of each hospital shall be in accordance with AB 774, AB 1020, SB 350, SB 1276 and the federal PPACA (Patient Protection and Affordable Care Act)

- Signage about the availability of financial assistance will be posted in registration areas of hospitals including emergency rooms and all patient access areas.
- A Notice of Collection Practices shall be provided to all patients (guarantors) during registration and included in the final billing statement.
- This policy shall be widely publicized throughout the CRMC including not limited to the CRMC website and otherwise be made available upon request.
- Financial Questionnaires shall be available in all registration/ patient access areas.
- CRMC staff including Admitting/Registration and Financial Counseling staffs as well as on site consultants such as Health Advocates will comprehensively screen patients for possible third-party coverage, including private health insurance (Covered California Health Exchange), Medicare, Medicaid, and other state programs and assist patients in applying for coverage when appropriate.
- Self-Pay bills shall include the following:
  A. Statement of Charges
  B. A request that the patient inform the hospital if the patient has insurance coverage and that if the patient does not have coverage that they may be eligible for Medicare,

Healthy Families, Medicaid, insurance through the California Health Exchange, other state or county programs and charity.

C. A statement indicating how the patient may obtain an application or apply for the aforementioned programs along with a referral to the local consumer assistance office at a local legal services office.
    i. Note: If the patient or patient's representative indicates the patient has no third-party coverage and requests a discounted rate or charity, the patient shall be provided with an application for the Medicaid program, Healthy Families program or other applicable state or county program.
D. Information on the hospital's financial assistance and charity program applications including a statement that if the patient lacks or has inadequate insurance and meets certain low-income requirements they may qualify for discounted payment or charity care. A telephone number for additional information on the hospitals discount payment and charity program should accompany this statement.
E. Verification that a patient does not qualify for third party coverage or is ineligible for a government program is required before finalizing a charity decision.
F. Patient eligibility with no application. Instances where a Financial Assistance Application is not required per charity definitions:

- Treatment Authorization Request (TAR) denials, Medicaid non-covered services, and untimely Medicaid billing write-offs wilt be recorded with their respective adjustment codes. Medicare/Medicaid accounts are written off to a respective adjustment code to be captured for Medicare Bad Debt reimbursement.
- Finance will identify the amounts posted to those codes and transfer those amounts from contractual to charity in the general ledger.
- For Medicare/Medicaid adjustments, that portion not claimed as Medicare bad debt reimbursement wilt be reclassified as charity.
- A patient may be verified as homeless at any time during the revenue cycle. The Charity Care eligible portion of the account will be adjusted using adjustment code 88870852 — "Charity Discount".
- CRMC facilities will not engage in extraordinary collection efforts including referral to outside collection agencies before making a reasonable effort to determine whether the patient qualifies for financial assistance. Upon referral, outside collection agencies, in their collection activities, including when performing income and asset searches in preparation for lawsuit authorizations, can verify an inability to pay and can submit the account for charity approval under the following circumstances:
- Self-pay patients with gross incomes at or below 400% of Federal Poverty Guidelines. The entire balance will be deemed charity.
- Self-pay patients with gross incomes in excess of 400% but less than 500% of FPG, and limited assets, may qualify for partial or full charity. The liability for this income group in all cases will never be more than the expected reimbursement from Medicare. For self-pay patients with gross incomes in excess of 500% of FPG, the patient's liability will be the self-pay discount rate in effect at time of service. Lastly, insured, and self-pay patients with incomes less than 500% of FPG and healthcare expenses exceeding 10% of annual income during the past 12 months will be eligible for full charity.
- Equity in a principal residence can be considered in asset determination only when income is in excess of 500% of Federal Poverty Guidelines, and a lien against that equity can be approved, but in no instance will foreclosure proceedings be initiated. PHSSC and its

collection agencies will wait until the principal residence is sold or refinanced to collect its debt. California law places restrictions on monetary assets that can be considered in making an ability to pay determination. Consistent with California laws, monetary assets shall not include: (1) assets held under a qualified retirement plan; (2) the first ten thousand dollars ($10,000) of a patient's monetary assets; or (3) fifty percent (50%) of a patient's monetary assets in excess of $10,000.

- Patient Eligibility as established by financial need per Financial Questionnaire.
- All CRMC employees including registration staff, financial counselors, patient access representatives, patient account representatives, clinical social workers, nurses, case managers, chaplains as well as mission directors and medical staff physicians during their normal course of duties, can identify potential inability to pay situations and must refer the patients for financial counseling.
- Clinical social workers identifying potential charitable services cases should liaison with financial counselors/patient access representatives in evaluating charity potential and presenting financial assistance options to the patient/family.
    - In these instances, a Financial Questionnaire can be offered to the patient/family and the account is accordingly documented to help guide future collection efforts.
- The Financial Questionnaire must be accompanied by proof of income, including copies of recent paychecks, W-2 statements, income tax returns, and/or bank statements showing payroll deposits. If none of these documents can be provided, one of the following is required:
    - If the patient/responsible party is paid in cash, a letter from the employer providing the rate of pay.
    - If there is no employer/employee arrangement, other written documentation of in-kind income can be considered, on a case-by-case basis.
    - Patients may request a Financial Assistance Application by calling the CBO, writing to the mailing address on their patient billing statement, or downloading the form from the CRMC websites.
    - Patients completing Financial Questionnaire are responsible for making reasonable effort to supply the information needed to make a determination. Failure to provide that information may result in a denial of the Financial Questionnaire.
- Financial Assistance Application Review/Approval Process:
    - For restricted services charity write-offs, or homeless patient charity write-offs, the write-off transaction can be initiated by any CBO employee. Standard transaction approval levels will apply.
    - A Financial Questionnaire must be reviewed by a financial counselor. If gross income is at or below 400% of FPG, the counselor may approve the charity application, based on the information submitted with the application (proof of income is required). If the gross income is more than 400% but less than 500% of FPG, an assessment for qualification of partial or full charity based on income, assets, and medical debt load will be made by the financial counselor with write-offs subject to standard approval levels.
    - Financial Questionnaire shall be reviewed and approved, denied or returned to the patient with a request for additional information within fifteen (15) business days of receipt.

- Collection agency requests for charity or Financial Questionnaire received from a collections agency shall be reviewed by Central Business Office (CBO). The CBO shall follow the review process described in (b) above in determining ability to pay and approving partial, total or no charity.
- If charity is approved at 100%, any patient deposits paid toward accounts approved for charity must be refunded to the account guarantor. This does NOT apply to any third-party payments, including casualty insurance payments or settlements paid from attorney trust accounts. Those payments will be retained, and charity will be granted for the difference between gross charges and the sum of those excluded payments. Refunds under this provision will include interest at the rate prescribed in Section 685.010 of the Code of Civil Procedure.

- Notification of charity determination:
  - For homeless charity write-offs, no notification is necessary.
  - In all instances where a Financial Questionnaire was submitted, the person approving the application shall submit a written determination of no charity, partial charity or full charity to the person who submitted the applications on behalf of the patient within fifteen (15) days of final determination of the completed application.
  - In the event partial or no charity is approved, the notification letter will advise that the patient may appeal the determination.
  - Appeals should be in writing to:

    Corona Regional Medical Center
    Attn: Patient Access Services
    800 S Main St
    Corona, California 92882
  - The CBO shall respond to all charity denial appeals. Should the patient's appeal be denied, and the original denial upheld, collection activities will be restarted to afford the patient ample opportunity to make payment, per the provisions of applicable state law.
  - If partial charity is approved, the remaining patient balance may be paid in interest-free installments as mutually agreed between patient and facility. If a payment plan cannot be agreed upon mutually, the "Reasonable Payment Plan" as defined will be applied. Payment will not be considered delinquent, nor will further collection activity occur, as long as any payments made pursuant to a payment plan are not more than 90 days delinquent under the terms of that plan. If an outside collection agency is utilized to collect the unpaid debt, that agency agrees to abide by the requirements of this policy and of AB 774, AB 1020, SB 350, and SB 1276, including not garnishing wages or placing a lien on a principal residence.

- Processing of charity write-off:
  A. If a self-pay discount has been issued, that discount must be reversed to restore full charges. This step permits Finance to apply a ratio of cost to charges against the amount of charity write-off to accurately determine the cost of charity care for external reporting purposes.
  B. The 100% charity discount percentage is then applied to the account, using existing adjustment codes.

C. A patient who paid a deposit at the time of service and is entitled to 100% charity, or a patient who paid a deposit and is entitled to partial charity and whose deposit exceeded the final liability per the charity policy, is entitled to both a refund of the excess or full deposit plus interest at the rate prescribed in Section 685.010 of the Code of Civil Procedure. Should a partial charity account need to be referred to an outside agency for collection, the account will be flagged as a partial charity recipient so that the agency can assure that:
    i. It will not initiate a lawsuit for purposes of garnishing wages or attaching a lien on a principal residence; and
    ii. It will not report the delinquency to a credit-reporting agency until 180 days after the date of service, or 180 days after the patient received partial charity approval.