		Department: Patient Accounting	
		Document Owner/Author: Patient Accounting Manager	
		Category: Departmental	**Approval Type:** Triennial
Date Created 02/12/07	**Date Board Approved:** 01/09/17	**Date Last Review:** 01/04/2022	**Date of Next Review:** Triennial
Policy Name: Financial Assistance, Discount Payment, and Billing and Collection			

Click here for specific information on:
Review History

Purpose

This Policy and Procedure defines the eligibility criteria for El Centro Regional Medical Center ("ECRMC"), to provide the operational guidelines for the ECRMC Financial Assistance Program, and to outline the billing and collection process from uninsured patients or certain underinsured patients, including those who qualify for financial assistance under this Policy. This written Policy:

- Includes eligibility criteria for financial assistance, free and discounted (partial charity) care.
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy.
- Describes the method by which patients may apply for financial assistance.
- Describes how the hospital will publicize the policy within the community served by ECRMC.
- Limits the amounts that ECRMC will charge for healthcare provided to individuals eligible for financial assistance to amounts generally billed (and received) by ECRMC for Medicare patients.
- Describes billing and collection procedures.

In order to manage its resources responsibly, to allow ECRMC to provide the appropriate level of assistance to the greatest number of persons in need, and to comply with the provisions enacted in the Patient Protection and Affordable Care Act (PPACA), El Centro Regional Medical Center and ECRMC Board of Trustees establishes the following guidelines for the provision of patient charity care.

Scope

Policy Statement

ECRMC is committed to providing financial assistance to patients who have medically necessary healthcare needs and are low-income, uninsured, underinsured, incur high medical costs, are ineligible for a government program and are otherwise unable to pay for care based on their individual family financial situations. Consistent with our mission, ECRMC strives to ensure that the financial capacity of families who need healthcare services does not prevent them from seeking or receiving care. In the case of emergencies, there will be no delay in providing required screening or stabilization services in order to inquire about an individual's payment method or insurance.

All patients, including low income, uninsured, and underinsured patients, will be treated fairly and with respect before, during and after the delivery of healthcare, regardless of their ability to pay. All patients and patient families/representatives shall be treated with dignity and patient information shall be maintained as confidential in accordance with ECRMC policies and State and Federal laws. 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 ECRMC will be responsive to the patient's/guarantor's needs. Upon patient/guarantor request, ECRMC will provide a copy of this Policy and Procedure.

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

The Financial Assistance Program at ECRMC is available to provide discounted or free care to eligible patients for medically necessary services based upon the guarantor's income as defined by the Federal Poverty Level Guidelines (FPG). Medically necessary care is determined by a member of the ECRMC Medical Staff or through utilization of Emergency Care Center services.

ECRMC personnel will work with patients/guarantors to determine eligibility for governmental program assistance. State or County eligibility workers knowledgeable in the California Health Benefit Exchange, as well as government-sponsored health programs, such as Medicare, Medi-Cal, California Children Services (CCS), or other state or county-funded health programs will be made available to assist in determining eligibility and in completing the application process.

The Financial Assistance Program described by this Policy does not apply to elective procedures.

Information about ECRMC's Financial Assistance Program shall be made available through posted notices in the Emergency Care Center, registration areas, clinics, other outpatient settings, and on the ECRMC website. In addition, written notice shall be provided to potentially eligible patients during the registration process or as soon as possible thereafter and during the billing process. This information shall be provided in English and Spanish, and will be translated for patients/guarantors who speak other languages.

Any member of ECRMC staff or Medical Staff may refer patients/guarantors to the ECRMC Financial Assistance Program. Any family member or representative of a patient may request financial assistance. ECRMC will determine or review eligibility for financial assistance any time information on the patient's/guarantor's eligibility becomes available.

Financial assistance is not considered to be a substitute for personal responsibility, and patient families or representatives are expected to cooperate by providing complete and accurate information in order to determine eligibility for the ECRMC Financial Assistance Program. Individuals who are eligible to apply for government programs as well as individuals with the capacity to purchase health insurance will be encouraged to do so as a means of assuring access to healthcare services. If a patient/guarantor applies, or has a pending application, for another health coverage program at the same time an application is submitted for financial assistance, neither application shall preclude eligibility for the other program.

A patient/guarantor who requests a discounted payment, charity care, or other assistance in meeting their financial obligation to ECRMC shall make every reasonable effort to provide ECRMC with documentation of income and health benefits coverage. If the person requests charity care or a discounted payment and fails to provide information that is reasonable and necessary for ECRMC to make a determination, ECRMC may consider that failure in making its determination.

In its billing and collection activity, ECRMC shall treat patients and patient families or representatives with fairness, dignity and respect. ECRMC shall not utilize wage garnishments, liens on a patient's primary residence, or body attachments in its collection activities. ECRMC shall utilize only those outside or third party collection agencies that agree to comply with applicable state and federal laws and with ECRMC policies, and ECRMC debt collection standards and practices, including ECRMC's definition and application of a reasonable payment plan.

In the implementation of this Policy and Procedure, ECRMC shall comply with all applicable federal, state and local laws, rules and regulations that may apply to activities conducted pursuant to this Policy and Procedure.

Responsibilities

Person/Title	Responsibilities

Procedure/Plan

FINANCIAL ASSISTANCE PROGRAM PROCEDURE

Identification

The identification of patients eligible for Financial Assistance is achieved through determination of financial status of an individual patient/guarantor by the ECRMC Financial Counseling department. Such determination should be made at or before the time of admission to ECRMC, or as soon as possible thereafter. In some cases, such as emergency admissions, it may not be possible to establish eligibility for Financial Assistance until after the patient is discharged. ECRMC recognizes that determinations cannot always be made at the time of service and therefore provide the patient/guarantor with an adequate amount of time to apply for Financial assistance. All applications for Financial Assistance must be submitted no later than 240 days from the date of initial patient billing. If the guarantor has extraordinary circumstances preventing them from applying for Financial Assistance or has made reasonable effort to communicate with ECRMC, the time restraint may be waived.

Third-party coverage

A. ECRMC shall make all reasonable efforts to obtain from the patient/guarantor information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by ECRMC, including, but not limited to, any of the following:

1. Private health insurance, including coverage offered through the California Health Benefit Exchange.
2. Medi-Cal, California Childrens' Services or other state-funded benefit programs designed to provide health coverage.
3. Medicare.
4. Other coverage, including workers' compensation, automobile insurance or other insurance.

B. If a patient/guarantor does not indicate coverage by a third-party payor, or requests Financial Assistance that may include a discounted price or charity care, then ECRMC shall provide an application for Medi-Cal or other governmental program to the patient/guarantor (to the extent available to ECRMC). This government sponsored benefit program application shall be provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care.

Responsibility for determining eligibility

The responsibility for determining a patient's/guarantor's eligibility for Financial Assistance at,

or before, the time of the admission, or during the inpatient stay, or after discharge to the hospital shall be with the Financial Counseling department. This will require that the patient/guarantor complete the Financial Assistance Application, along with the necessary copies of documentation, to determine the annual family income of the patient/guarantor.

Method by which patients may apply for charity care – Application

ECRMC will request that each patient/guarantor applying for Financial Assistance complete a Financial Assistance Application, including a Statement of Financial Condition. The Assistance Application allows for the collection of needed information to determine eligibility for Financial Assistance. Financial assistance may be granted at any time eligibility is determined. The ECRMC Financial Counseling department may assist with completing the Financial Assistance Application.

A. Calculation of Immediate Family Members - ECRMC will request that patients/guarantors verify the number of people in the patient's household.

1. Adults – ECRMC will count the total number of adults residing in the home.
2. Minors – For persons under the age of 18. In calculating the number of people in a minor patient's household, ECRMC will include the patient, and other dependents of the patient's parents or caregivers (or calculate as other dependents of the patient's mother and other dependents of the patient's father; similarly for other dependents of stepparents residing in the home), and any other dependent family members residing in the home.

B. Calculation of Income

1. Annual family income before taxes, less payments made for alimony and child support.
2. Proof of income may be determined by annualizing the year-to-date family income, giving consideration for current earning rates.

C. Patient's/Guarantor's Responsibility

1. All hospital patients/guarantors bear certain responsibilities including:
   a. Providing accurate and complete information in a timely manner so that ECRMC can process the request for Financial Assistance;
   b. Responsiveness – provide timely follow-up for additional documents or information ECRMC requires for the Financial Assistance application process;
   c. Full disclosure of the required information; and
   d. Satisfaction of any patient/guarantor payment obligation.

Income Verification

ECRMC 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 collected for year prior to date of admission.

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

1. Tax returns (preferred income verification document)
2. Recent pay stubs/paycheck remittance
3. IRS form W-2
4. Wage and Earnings Statement
5. Social Security income
6. Workers' Compensation or unemployment compensation determination letters
7. 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, ECRMC 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.

ECRMC shall not include retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified 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, ECRMC will work with the patient/guarantor on flexible payment plans.

The requested documents to verify income should be made available to ECRMC within 14 calendar days. Patient/guarantor may submit copies of the required documents with the Financial Assistance Application.

Documentation Unavailable –

When a patient/guarantor is unable to provide the requested documentation to verify income, ECRMC will require that a satisfactory explanation of the reason the patient/guarantor is unable to provide the requested documentation be noted on the Financial Assistance Assessment Form. In cases where the patient/guarantor is unable to provide documentation verifying income, ECRMC may at its sole discretion verify the patient/guarantor income in either one of the following two ways:

1. By having the patient/guarantor sign the Assistance Application attesting to the veracity of the income information provided and a written explanation as

to why they are unable to obtain and/or provide documents; or

2. Through the written attestation of ECRMC personnel completing the Assistance Application that the patient/guarantor verbally verified ECRMC's calculation of income.

The application should then be submitted to the Patient Financial Services Director for review to determine eligibility.

Eligibility Cannot be Determined

If and when ECRMC personnel cannot clearly determine eligibility, ECRMC personnel will use best judgment and submit a memorandum listing reasons for judgment along with any available documentation to the Patient Financial Services Director. The Patient Financial Services Director will then review the memorandum and documentation, and make a determination.

1. If the PFS Director agrees to approve eligibility, he or she will sign the Eligibility Determination Worksheet and continue with the normal approval process.
2. If the PFS Director recommends denying financial assistance based on the information provided and the difficulty in determining eligibility, he or she will notate the application with the decision and return all documentation to the Financial Counselor for denial processing.

Classification Pending Income Verification – During the income verification process, while ECRMC is collecting the information necessary to determine a family's income, the patient may be treated as a self-pay patient in accordance with ECRMC policies.

<u>Information Falsification</u>

Falsification of information may result in denial of the Financial Assistance Application. If, after a patient is granted Financial Assistance and ECRMC finds material provision(s) of the Assistance Application to be untrue, the Financial Assistance may be withdrawn.

<u>Request for additional information</u>

If adequate documents are not provided, ECRMC will contact the patient's family to request additional information/documentation. If the patient's family does not comply with the request within 14 calendar days from the date of the request, such non-compliance will be considered an automatic denial for Financial Assistance. A note will be input into the hospital computer system and any and all paperwork that was completed will be filed according to the date of the denial. No further actions will be taken by ECRMC personnel. If requested documentation is later obtained, all filed documentation will be reviewed and the patient/guarantor will be reconsidered for Financial Assistance.

<u>Non-emergent Financial Assistance</u>

This policy does not cover non-emergent elective or specialized procedures or services/procedures that are not medically necessary.

International Patients

The ECRMC Financial Assistance program does not apply to international patients. International patients seeking non-emergent care or elective services will continue to follow standard operating procedures for providing payment up-front according to ECRMC policy.

Automatic Classification as eligible for Financial Assistance

The following is a list of types of accounts where Financial Assistance is considered to be automatic and documentation of income or Financial Assistance application is not needed:

Medi-Cal accounts – Exhausted Days/Benefits
Medi-Cal spend down accounts
Medi-Cal Dental denials
Medicare Replacement accounts with Medi-Cal as secondary, where Medicare Replacement plan left patient's family with responsibility

Homeless:

If the patient is determined to be homeless he/she will be deemed eligible for the Financial Assistance Program.

Elopement or Inaccurate/Invalid Information:

Patients seen in the emergency department, for whom the hospital is unable to issue a billing statement, due to the patient leaving prior to conclusion of treatment in the emergency room or providing inaccurate or invalid information, may have the account charges written off as Charity Care. All such circumstances shall be identified on the patient's account notes as an essential part of the documentation process.

Denials, Non-Covered Charges & Medicare Bad Debts:

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

Medicare:

Any evaluation for financial assistance relating to patients covered by the Medicare Program must include a reasonable analysis of all patient assets, liabilities, income and expenses, prior to eligibility qualification for the Financial Assistance Program. Such financial assistance evaluations must be made prior to service completion by ECRMC.

The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payer including Medi-Cal/Medicaid, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as charity care if:

1. The patient is a beneficiary under Medi-Cal/Medicaid or another program serving the health care needs of low-income patients; or

2. The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

Criteria for Re-Assignment from Bad Debt to Charity Care

Non-Payment of Balance Due:

Any account returned to the hospital from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, may be deemed eligible for Charity Care. Documentation of the patient or family representative's inability to pay for services will be maintained in the Charity Care documentation file.

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

- Patient accounts must have no applicable insurance (including governmental coverage programs or other third party payers); and

- The patient or family representative must have a credit score rating within the lowest 25th percentile of credit scores for any credit evaluation method used; and

- The patient or family representative has not made a payment within 150 days of assignment to the collection agency;

- The collection agency has determined that the patient/family representative is unable to pay; and/or

- The patient or family representative does not have a valid Social Security Number and/or an accurately stated residence address in order to determine a credit score

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

Determination of Financial Eligibility and Level of Financial Assistance

Criteria to receive Financial Assistance for medically necessary care is based on the income threshold criteria dictated by the Federal Poverty Guidelines set at the time the patient completes the application process. For the purpose of this policy, Self Pay means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, Medi-Cal, and whose injury is not a compensable injury for purposes of worker's compensation, automobile insurance, or other insurance as determined and documented by ECRMC. Self pay patients may include charity patients.

A. There are three categories of financial eligibility – Financially Qualified Self-Pay; High Medical Cost; or Private Self-Pay.

1. Financially Qualified Self-Pay: Defined as **no third-party insurance or other coverage** and family income **does not exceed** 500 percent of the Federal Poverty Level. The level of assistance (which could include free care or discounted payment) will depend upon family income.

2. Patients with "High Medical Costs": Patients/guarantors **with third-party insurance or other coverage** and whose family income does not exceed 400 percent of the Federal Poverty Level. " High medical costs" means any of the following:

   i. Patient/guarantor has out-of-pocket medical expenses within the prior 12 months that exceed 10 percent of family income (medical expenses include both incurred at ECRMC and outside of ECRMC. If outside of ECRMC, patient/guarantor must provide documentation of medical expenses); or
   ii. Patient/guarantor has annual out-of-pocket costs incurred at ECRMC that exceed 10 percent of the patient's/guarantor's family income in the prior 12 months.

   Eligible high medical cost patients/guarantors may receive a discount to their bill.

3. Private Self Paypatients: Defined as patients/guarantors who **do not have third- party insurance or other coverage** and whose family income **exceeds** 500 percent of the Federal Poverty Level. Eligible private self-pay patients

shall be provided a prompt pay discount. Patients/guarantors must either make payment, or make payment arrangements, or be in process with eligibility applications for government-sponsored insurance programs or with the ECRMC Financial
Assistance program within thirty days, or the patient/guarantor will be responsible for all charges. For self-pay patients not eligible for the ECRMC Financial Assistance Program, all patients must leave a deposit of 30 percent of the total amount of charges prior to service.

B. Eligibility for free care

1. Uninsured patients/guarantors whose household income, as determined in accordance with the Assistance Application, is less than or equal to 100 percent of the poverty guidelines, will receive care free of charge, except uninsured patients/guarantors at or below 100 percent of the FPL must pay a co-payment according to the co-payment schedule:

Hospital Service	**Co-Payment**
Emergency Care	$50.00/visit
Inpatient Admission	$100.00/per day, not to exceed $1,000
Emergency Care Center resulting in an Inpatient Admission	ER Co-Pay waived and Inpatient Co-Pay applies

Other than the instant co-payment, (which may be waived for deceased patients), ECRMC's collection policy is not to bill these patients/guarantors for any amount.

C. Eligibility for discounted payment

1. An uninsured patient/guarantor who does not qualify for free care under this policy because the patient's/guarantor's household income exceeds 100 percent of the Federal Poverty Guidelines may be eligible to receive discounts in accordance with financial need as determined by the FPG as follows:

   a. For patients/guarantors with household income between 101 percent and 400 percent of the Federal Poverty Level, provide a discount, whereby the expected reimbursement would be equivalent to Medicare reimbursement rates.
   b. For patients/guarantors with household income between 401 percent and 500 percent of the FPL, provide a discount of 50 percent off of charges.

c. For patients/guarantors with household income greater than 500 percent of the FPL, patients will be provided a 35 percent discount off of charges.

2. ECRMC Maximum Payment

a. For patients who are determined to be financially qualified self-pay or financially qualified with high medical costs, payment for services rendered shall not exceed the amount ECRMC receives from Medicare.

Interest Free, Extended payment plans

When a determination of discount partial charity has been made by the hospital, the patient shall have the option to pay any or all outstanding amount due in one lump sum payment, or through a reasonable scheduled term payment plan. At the option of the patient/guarantor, the patient/guarantor may choose an interest free extended payment plan to allow payment of the discounted price over time. ECRMC and the patient/guarantor will negotiate the terms of such a payment plan. In negotiating the payment terms, ECRMC will consider relevant factors, such as size of payment obligation, patient resources and essential living expenses, and any other relevant factors brought to ECRMC's attention. Individual payment plans will be arranged based upon the patient's ability to effectively meet the payment terms. As a general guideline, payment plans will be structured to last no longer than 12 months. The hospital shall negotiate in good faith with the patient; however there is no obligation to accept the payment terms offered by the patient. If the hospital and the patient/guarantor cannot agree on the payment plan, the hospital shall use the following formula to create a "reasonable payment plan":

> "Reasonable payment plan" 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 child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

No interest will be charged to the patient for the duration of any extended payment plan arranged under the provisions of the Financial Assistance Policy. Any patient who fails to pay their portion will be referred to an outside collection agency for further collection process. ECRMC may declare an extended payment plan no longer operative after the patient's failure to make all consecutive payments due during a 90-day period. Before declaring the extended payment plan no longer operative, ECRMC, it's collection agency, or assignee shall make a reasonable attempt to contact the patient by telephone and, to give notice in writing, that the extended payment plan may become inoperative, and notify the patient/guarantor of the opportunity to renegotiate the extended payment plan. Prior to the extended payment plan being declared inoperative, ECRMC, it's collection agency, or assignee shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. ECRMC, it's collection agency, or assignee shall not report adverse information to a consumer credit reporting agency or commence a civil action against the patient/guarantor for nonpayment prior to the time the extended payment plan is declared to be no longer operative. The notice and telephone call to the patient may be made to the last known telephone and address of the patient/guarantor.

For financially qualified patients with high medical costs, discounts shall be determined via the catastrophic eligibility under the provisions of this Policy.

Catastrophic Eligibility

ECRMC will provide catastrophic eligibility Financial Assistance when patient/guarantor liability exceeds a substantial portion of the patient's/guarantor's income, including high medical cost patients as defined previously in A.2. To qualify for Catastrophic Eligibility, the patient/guarantor must meet the expense qualification as follows:

Expense qualification:

A. Upper limit liability ceiling: For patient's/guarantor's with household income between 101 percent and 400 percent of the FPL, the patient's/guarantor's liability must exceed 10 percent of their household income, which will be determined by completing the Upper Limit Patient Liability Worksheet.
B. Upper limit liability ceiling: For patient's/guarantor's with household income greater than 400 percent of the FPL, the patient's/guarantor's liability must exceed 20 percent of their household income, which will be determined by completing the Upper Limit Patient Liability Worksheet.
C. To determine expense qualification for catastrophic eligibility using the Upper Limit Patient Liability Worksheet:

    1. ECRMC will multiply the household income, as determined by following the Financial Assistance Eligibility Determination Worksheet, by either 10 percent for incomes between 101 percent to 400 percent of the FPL or by 20 percent for incomes greater than 400 percent of the FPL.
    2. ECRMC will determine the patient's/guarantor's medical expense liability.
    3. ECRMC will compare the appropriate Upper Limit Liability ceiling of the patient's/guarantor's household income to the total amount of the patient's/guarantor's medical expense liability. If the total of the medical expense liability is greater than the upper limit liability ceiling of the patient's/guarantor's household income, then the patient/guarantor meets the Catastrophic Eligibility qualification. ECRMC will subtract the upper limit liability ceiling of the patient's/guarantor's income from the medical expense liability to determine the amount by which the medical expenses exceed the available household income; this amount is then eligible for a charity care write-off.

Time Requirements for Determination

A. While it is desirable to determine the amount of Financial Assistance for which a patient/guarantor is eligible as close to the time of service as possible, ECRMC recognizes that determinations cannot always be made at the time of service. In

some cases, eligibility is readily apparent and a determination can be made before, on or soon after the date of service. In other cases, it can take investigation to determine eligibility, particularly when the patient/guarantor has limited ability or willingness to provide needed information. Therefore, ECRMC provides the patient/guarantor with an adequate amount of time to apply for Financial Assistance. All applications for Financial Assistance must be submitted no later than 240 days from the date of initial patient billing, unless extraordinary circumstances have occurred preventing the patient/guarantor from applying.

B. Every effort should be made to determine a patient's/guarantor's eligibility for Financial Assistance. In some cases, a patient/guarantor eligible for Financial Assistance may not have been identified prior to initiating external collection action. Accordingly, collection agencies contracted to work with ECRMC shall be made aware of the policy on "Financial Assistance, Discount Payment, and Billing and Collection". This will allow the agency to report amounts that they have determined to be uncollectable due to the inability to pay in accordance with ECRMC's Financial Assistance eligibility guidelines.

Approval Procedures

ECRMC personnel will complete a Financial Assistance Eligibility Determination Worksheet and attach to the patient/guarantor Financial Assistance Application, along with the copies of required documents, and then forward to the Patient Financial Services Director for review and approval.

A. The Financial Assistance Eligibility Determination Worksheet with the application for Financial Assistance allows for the documentation of the administrative review and approval process utilized by ECRMC to grant financial assistance. The Patient Financial Services Director must approve any revision to the Financial Assistance Eligibility Determination Worksheet.

1. For patient/guarantor accounts meeting the Financial Assistance eligibility criteria, the Application for Financial Assistance may be approved for medically necessary healthcare services.

2. If the application is approved and the patient needs to return for care, the approval is extended for six months for all medically necessary healthcare services on balances that can be considered for Financial Assistance.

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

Manager of Patent Accounting: Accounts less than $2,500
Chief Financial Officer: Accounts less than $10,000

Chief Executive Officer: Accounts greater than $10,000

Each level requires the review, approval and signature of the person authorized to approve at that level prior to an application for a larger medical expense liability moving forward for approval by the additional designated authorized signers.

The accounts will be filed according to the date the Financial Assistance adjustment was entered onto the account.

Governmental Assistance

In determining whether each individual qualifies for Financial Assistance, other county or governmental assistance programs should also be considered. Many applicants are not aware that they may be eligible for assistance such as Medi-Cal, Victims of Crime, or California Childrens' Services.

ECRMC Financial Counselors shall assist families in determining if they are eligible for any governmental or other assistance and are available to assist with the application process.

Persons eligible for programs such as Medi-Cal but whose eligibility status is not established for the period during which the medical services were rendered, may be granted Financial Assistance for those services. ECRMC may make the granting of Financial Assistance contingent upon applying for governmental program assistance.

Ineligibility for Financial Assistance

If ECRMC determines that the patient/guarantor is not eligible for Financial Assistance under this policy, it shall notify the patient/guarantor of the denial in writing. The Financial Counselor shall coordinate the processing and mailing of these communications.

Medi-Cal Share of Cost-NO WAIVER

Patient obligations for Medi-Cal/Medicaid share of cost payments will NOT be waived under any circumstance. However, after collection of the patient share of cost portion, any other unpaid balance relating to a Medi-Cal/Medicaid patient may be considered for Charity Care.

Contracts/Discounts

Any Non-Obstetrical patients, including Physicians, who have been offered Financial Assistance but have declined, will be provided a 30% discount for services paid in full within 30 days of the date services were rendered. This discount offer cannot be combined with any of the aforementioned Financial Assistance discounts. This is only for those uninsured or underinsured patients not interested in applying for Financial Assistance.

For Obstetric patients, a special contract is used to determine the Cash Price due prior to discharge. This contract is available to all uninsured or underinsured obstetric patients at the time of pre-admission or admission for walk-in patients. The Cash Price includes the baby, providing there are no complications with the birth. The rates are equivalent to the average Medi-Cal

reimbursement for 2-day Vaginal deliveries and 3-day Cesarean Section deliveries. Additional fees apply to those with Extended Stay, NICU babies, Twins and Tubal Ligations and any other accounts outside the delivery of the baby.

Notices

ECRMC shall provide written information about the availability of the ECRMC Financial Assistance Program, which shall include information about eligibility, to uninsured, underinsured or self-pay patients. These notices will be published in English and Spanish, and translated for patients/guarantors who speak other languages. Written notice shall include, at a minimum, the following:

1. If a patient meets certain income requirements, the patient may be eligible for a government-sponsored program or the ECRMC Financial Assistance Program.
2. Identification of a hospital phone number with hours of availability shall be delineated so that patients may call to obtain further information about financial assistance.
3. ECRMC website that provides such notice.

Locations

Written notice shall be handed to potentially eligible patients/guarantors in the inpatient, outpatient and Emergency Care Center areas and shall be explained, so that the patient/guarantor is informed about the availability of government sponsored programs and the ECRMC Financial Assistance Program.

Posted notice shall be conspicuously and clearly posted in locations that are visible to the public, including, but not limited to:

i. Emergency Care Center;
ii. Billing office;
iii. Registration areas;
iv. Other outpatient settings.

Written correspondence to the patient/guarantor shall be in English or Spanish.

Full Charity Care and Discount Partial Charity Care Reporting

ECRMC will report actual Charity Care provided in accordance with regulatory requirements of the Department of Health Care Access and Information (HCAi) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. To comply with regulation, the hospital will maintain written documentation regarding its Charity Care criteria, and for individual patients, the hospital will maintain written documentation regarding all Charity Care determinations. As

required by HCAi, Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.

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

Document Retention Procedures

ECRMC will maintain documentation sufficient to identify each patient/guarantor who qualifies for Financial Assistance, the patient family's income, the method used to verify the patient family's income, the amount owed by the patient/guarantor, and the person who approved or denied granting Financial Assistance. All documentation will be retained within ECRMC's Business Office for one calendar year. After which, the documents will be boxed and marked as "Charity Documents" with appropriate dates, and then forwarded to long-term storage, where the records will be retained for an additional six years before shredding.

Reservation of Rights

It is the policy of ECRMC to reserve the right to approve, limit or deny Financial Assistance at the sole discretion of ECRMC.

Application of Policy

The Financial Assistance policy does not apply to those services outside of ECRMC. This policy does not create an obligation to pay for any charges or services not included in the ECRMC bill at the time of service. This policy may not apply to professional services rendered by physicians or other medical providers at ECRMC, including, but not limited to, anesthesiologists, radiologists, certain surgeons and medical specialists.

ECRMC's contracted Emergency Physicians and Radiology Groups will take into consideration ECRMC's Financial Assistance Program and shall implement their own financial assistance and discounted payment policies. Upon approval or denial of financial assistance, notification will be made to the aforementioned groups by the ECRMC Financial Counselor and documented in the patients account. See AB 1503, effective 01/01/2011. Contact information for ancillary providers is provided to the patient in the Important Patient Information notice and the Ancillary Services Provider handout. These notices are provided at the time of Registration to every patient who presents to El Centro Regional Medical Center for services.

BILLINGANDCOLLECTION PROCEDUREFORFINANCIALLYELIGIBLE PATIENTS

Billing Notices

When sending a bill to patients/guarantors potentially eligible for a government program or the ECRMC Financial Assistance Program, ECRMC will include the following:

1. Statement of charges for hospital services;
2. Request for information regarding health insurance coverage, Medicare, Healthy Families Program, Medi-Cal or other coverage;
3. Statement that indicates that if the patient/guarantor lacks, or has inadequate insurance coverage, the patient/guarantor may be eligible for Medicare, Medi-Cal, Healthy Families, California Children's Services, coverage offered through the California Health Benefit Exchange, other state- or county-funded health coverage, or for the ECRMC Financial Assistance Program, if certain low to moderate income requirements are met;
4. Statement indicating how to obtain applications for Medi-Cal and Healthy Families programs, coverage offered through the California Health Benefit Exchange, or other state- or county-funded health coverage programs and how to obtain applications from ECRMC;
5. The telephone number of the appropriate department at ECRMC to obtain further information on applying for health coverage or financial assistance and how to apply for such assistance.
6. Statement providing patients with a referral to a local consumer assistance center housed at legal services offices (ie Health Consumer Alliance)

Overpayments

In the event of an overpayment by a patient/guarantor, ECRMC shall abide by the reimbursement terms and conditions set forth in Section 127410 of the California Health and Safety Code. ECRMC shall utilize reasonable efforts in processing overpayments and repaying the patient/guarantor as soon as possible.

Collection Activities by ECRMC

In determining the debt that ECRMC seeks to recover, ECRMC will consider only the income and certain monetary assets of the patient/guarantor eligible for the ECRMC Financial Assistance Program. In making this determination, ECRMC will not consider retirement or deferred compensation plans (either qualified or non-qualified under the Internal Revenue Code), the first $10,000 or the remaining 50 percent of the patient/guarantor's monetary assets.

ECRMC shall not use wage garnishments, body attachments or liens on primary residences of patients as a means of collecting unpaid patient bills.

Collection Actions by Outside Agencies

ECRMC shall not send patient/guarantor account(s) to an outside or third party collection agency for the purposes of commencing a civil action for nonpayment or take any action that would result in an adverse consumer credit report prior to 180 days. That time may be extended if the patient/guarantor is appealing a coverage decision and patient/guarantor makes a reasonable effort to communicate with ECRMC Patient Financial Services regarding the progress of the appeal.

The Patient Financial Services Director shall be authorized to review and approve any accounts referred to collection and shall establish procedures to refer accounts to outside collection agencies.

ECRMC shall not send an account to a collection agency if the patient has a pending application for the ECRMC Financial Assistance Program or government program or is attempting in good faith to settle an outstanding bill by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount. A "pending application" is defined as an application that has been fully completed and includes copies of the required documentation by the patient/guarantor, submitted to the relevant public agency in the case of government programs and to ECRMC in the case of the ECRMC Financial Assistance Program.

Prior to commencing collection action by an outside agency, ECRMC, or its designee, shall send the patient/guarantor a written notice summarizing his/her rights under State and Federal debt collection law and a statement regarding the availability of nonprofit credit counseling services.

Outside Collection Activities Follow ECRMC Collection Policies

ECRMC shall utilize only those outside collection agencies that have agreed in writing to comply with those collection standards and practices outlined in this Policy and Procedure, including ECRMC's definition and application of a reasonable payment plan. In addition, ECRMC may further define the standards and scope of practice to be used by such collection agencies, and shall obtain written agreements from such agencies that they will adhere to such standards and scope of practice. See also Interest Free, Extended Payment Plans

ECRMC shall utilize only those outside collection agencies that also have agreed as follows:

1. To comply with applicable state and federal debt collection practices law, including but not limited to hospital collection practices set forth in California Health and Safety Code Section 127425(a-h);
2. To not use a wage garnishment, except by court order, following the procedure set out under state law, including California Health and Safety Code Section

127425(f)(2)(A);

3. To not establish a lien on the patient's primary residence except as permitted under state law, including California Health and Safety Code Section 127425(f)(2)(B).

RESERVATION OF RIGHTS AGAINST THIRD PARTIES

Nothing in this Policy shall preclude ECRMC from pursuing reimbursement from third party payers, third party liability settlements or tortfeasors or other legally responsible third parties.

Good Faith Requirements

ECRMC makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate.

Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, or purposely inaccurate information has been provided by the patient or family representative. In addition, ECRMC reserves the right to seek all remedies, including but not limited to civil and criminal damages from those patients or family representatives who have provided fraudulent or purposely inaccurate information in order qualify for the ECRMC Financial Assistance Program

DISPUTE RESOLUTION PROCESS

Any dispute regarding eligibility, determination of financial assistance, or billing or collection should be directed to the Patient Financial Services Department.

The PFS Department shall obtain all information regarding the dispute and forward to the PFS Manager. If the Manager determines that an application for Financial Assistance should be reviewed, she or he should forward the new information to the PFS Director, or designee, for reprocessing.

The Patient Financial Services Director shall review and respond in writing to the patient family or representative regarding the results of his/her review.

Any appeal by the patient family or representative from the determination by the Patient Financial Services Director will be directed to the Chief Financial Officer whose determination will be final.

ACCESS TO POLICY AND RELATED DOCUMENTS

Copies of the written notices provided to patients, summary of the ECRMC Financial Assistance Program policy and procedure, and application forms in English and in Spanish are available on the ECRMC website.

Upon request to ECRMC Financial Counselors, patient families or representatives may obtain a complete copy of this Policy and Procedure.

Definitions

Term	Definition

Associated Policies/Plans/Protocols/Procedures/Forms

Title	Number	Location *(Hyperlink)*

References

State of California AB774 (Chapter 755, Statutes of 2006)
State of California AB1503 (Chapter 445, Statutes of 2010)
State of California SB1276 (Chapter 758, Statutes of 2014)
California Health & Safety Code Sections 127400127446
State of California AB1020 (Chapter 473, Statutes 2021)

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ECRMC El Centro Regional Medical Center An Agency Of The City Of El Centro		**Category:** Departmental	**Department:** Patient Accounting, Central Admitting-ER Registration.
		Policy Name: Financial Assistance, Discount Payment, and Billing and Collection	**Approval Type:** Department Specific

Date Rviewed /Aproved	By:	Title:	Procedure Notes:
02/09/07	Clark & Koortbojian	Consultants Charity Care	Reviewed
02/09/07	Foley Lardner	Hospital Attorneys	Reviewed
02/12/07	Kathleen Farmer	Chief Financial Officer	New policy required due to changes in hospital charity regulations due to the adoption of AB774; Replaces "Charity Care, Assisting Low Income Uninsured-Underinsured Patients (California Hospital Association guidelines)".
02/23/07	Finance Committee		Recommend forward to Board
02/28/07	Board of Trustees		Approved
07/09/08	Tisha Benavidez/K. Farmer	Patient Acctg Mgr/CFO	Revision to reflect option for 30% discount.
08/21/08	Clark Koortbojian Consultants	Charity Care Consultants	Reviewed
09/17/08	Personnel Committee		Recommend forward to Board of Trustees
09/24/08	Board of Trustees		Approved
05/26/09	Sylvia Castaneda	Admitting Manager	Reviewed
06/09/09	Kathy Farmer	CFO	Reviewed
06/17/09	Personnel Committee		Recommend forward to Board
06/24/09	Board of Trustees		Approved
07/27/10	Admin Team	Committee	Approved; no changes recommended.
02/11/11	David Aaron McDaniel	Director Patient Financial Services	Revised
07/09/13	Tisha Benavidez	Patient Financial Services Director	Annual Review; verbiage changed-policy intent not changed
07/09/13	Lidia Diaz	Patient Accounting Manager	Reviewed
07/15/13	Alex Wells	Chief Financial Officer	Reviewed and approved
07/15/13	Personnel & Policy	Committee	Triennial approval of TOC

07/23/13	Board of Trustees		Triennial approval of TOC
04/16/14	Linda Lawrence	Consultant	Added reference
08/12/14	Tisha Benavidez	Patient Financial Services Director	Added language to include time limit on filing for assistance
10/09/14	Alex Wells	Chief Financial Officer	Reviewed and approved
12/31/14	Tisha Benavidez	Patient Financial Services Director	Language added to comply with SB1276, eff 01/01/2015
01/09/14	Alex Wells	Chief Financial Officer	Reviewed and approved
01/09/17	Board of Trustees		Reviewed and approved
03/31/17	Tisha Benavidez	Patient Financial Services Director	Triennial Review; minor changes-policy intent not changed
04/07/17	Tyler Salcido	CFO	Reviewed and approved
01/04/2022	Virginia Torres	Patient Accounting Mangaer	Language added to comply with AB1020, eff 01/01/2022

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