Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		**Hovlid Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

COMMUNITY CARE FINANCIAL ASSISTANCE POLICY

POLICY:

Orchard Hospital realizes the need to provide service to patients who cannot otherwise afford health care. This policy is to provide financial assistance to patients who have health care needs and are uninsured, under-insured, ineligible for a government program, and are otherwise unable to pay for medically necessary care based on their individual circumstances.

A graduated schedule based on the annual HHS Poverty Guidelines, as well as assessment of the patient's monetary assets will be used to determine the qualifying income and asset levels of applicants. Guidelines are subject to change yearly based on the HHS Poverty Guidelines. Understanding this need, the hospital has chosen to fulfill their responsibility to the community by adopting the following Community Care Policy.

PROCEDURE:

1. Standard Eligibility Criteria for Participation in the Community Care Program:

a. A patient qualifies for Community Care if all of the following conditions are met:

- The patient does not have private health insurance (including coverage offered through the California Health Benefit Exchange), Medicare, or Medi-Cal as determined and documented by the hospital;

- The patient's injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital;

- The patient's household income does not exceed 75% (see matrix) of the Federal Poverty Level; **and**

- The patient's allowable monetary assets do not exceed $5,000;

1. In determining a patient's monetary assets, the hospital **shall not** consider:
   - Retirement or deferred compensation plans qualified under the Internal Revenue Code;
   - Non-qualified deferred compensation plans;
   - The first ten thousand dollars ($10,000) of monetary assets, and fifty percent (50%) of the patient's monetary assets over the first ten thousand dollars ($10,000).

b. Family size to determine federal poverty level is defined as follows:
- The patient's legal spouse or domestic partner
- The patient's legal guardian or parent
- Children under 21 whether living at home or not
- Care taker relatives

2. Basis for calculating amounts charged to patients:

a. In order to determine the maximum amounts for emergency and other medically necessary care for FAP eligible patients, the hospital uses the look back method to determine these amounts. Specific questions regarding amounts generally billed for emergency or medically necessary care can be directed to the Orchard Hospital Business Office at (530) 846-9020.

3. Special Eligibility and Enrollment Exceptions:

a. High Medical Costs/Medically Indigent
- A patient whose family income does not exceed 350% (see matrix) of the federal poverty and their annual out-of-pocket medical expenses for non-elective/medically necessary services with Orchard Hospital and other health care providers exceed 10% of the patient's family gross income in the prior 12 months, would then be considered as "Medically Indigent" as defined by AB774.

  1. For those who have been informally determined to be Medically Indigent, or have incurred high medical costs will be offered to complete a Community Care application by the Financial Counselor.

  2. Supporting documentation to show what medical expenses have been paid in the prior 12 months are required to determine eligibility.

b. Homeless/Indigent Patients

- Patients who are determined to be indigent/homeless by either clinical documentation or are unable to provide sufficient demographic information such as a mailing address, phone number, or residential address will/can be considered for Community Care.

    1. No application will be required by a patient who has been determined to be indigent/homeless.

    2. Only emergent/medically necessary services will be considered. Should a patient who presents for outpatient services, financial counseling will be done at the time of service.

c. Deceased No Estate

- Upon receipt of confirmation that a patient is deceased and who has no estate, third party coverage, or spouse, will be automatically eligible for Community Care upon receipt of the following items.
    1. Notification from county in which patient expired in.
    2. Received copy of death certificate from patient family notifying OH of death and no estate exists.
    3. Confirmation that patient does not have a living spouse who would be liable for outstanding/unpaid debt.
    4. Confirmation from another facility of patients' expiration and that no estate or pending probate exist.
    5. Upon notification from collections agency that collections accounts are being cancelled back due to deceased/no estate.
    6. Knowledge that patient has expired based on clinical documentation for services provided by OH.

d. Administrative Community Care

- In cases where medically necessary services are provided to a patient who has been screened by the financial counselor, and it has been determined that the patient is unable to complete the standard application process due to medical, social, or other documented circumstances, charges may be considered for Community Care on a case by case basis.

  1. Account(s) should be written up for Community Care adjustment with all supporting documentation attached and be presented to the Manager of Business Office/Registration and Chief Financial Officer for approval.

4. Standard Enrollment Process:

- An informal determination of Community Care eligibility will be determined by the Patient Financial Counselor and Credit/Collection Specialist, and the applicant may choose to fill out an application based on the recommendation of the Patient Financial Counselor and Credit/Collection Specialist; however, the recommendation of the Patient Financial Counselor and Credit/Collection Specialist is not required in choosing to fill out the Community Care Application.

- Upon being submitted for consideration by the Patient Financial Counselor and Credit/Collection Specialist, all properly submitted applications will be reviewed and considered for implementation within 10 business days.

- All application packets must be filled out completely and accurately with each of the following required documentation attached, to be considered:

  - Documentation of non-coverage from Medi-Cal for the service on the date performed;
  - Documentation of household income, as provided by:
    1. Current W-2 withholding form or Income Tax statement form from the previous year, **or**
    2. Pay stubs from the previous three months
  - Documentation of monetary assets, to include:
    1. Most current bank statement, and any additional information or statements on all monetary assets
       a. Statements on retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans **shall not** be included

Subject	Community Care Financial Assistance and Discount Payment Program				
Department(s)	Business Office and Compliance				
Reference #	4632				
Scope of Policy (Identifies the entities that are covered under the policy)					
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	Orchard Hospital		Medical Specialty Center (Oroville)		

2. Signed waiver or release from the patient or the patient's family, authorizing the hospital to obtain account information from financial and/or commercial institutions, or other entities that hold or maintain monetary assets, to verify their value.

- Completed Medicare Secondary Payer (MSP) Questionnaire indicating the patient's injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance

b. Any additional accounts with outstanding balances at time of application will be screened for Community Care eligibility using the same information collected above.
c. Verification of accuracy of application information, including contacting employers for verification of employment, will be made.
d. A letter of either approval or denial will be submitted to each applicant.

- The approval letter will include a demand statement for the service in question with adjustments and a balance of zero dollars ($0), and contact information for any questions that may arise;
- The denial letter will include: reason for denial; indication of potential eligibility under the Discount Payment Program, Payment Plan Program, or other self-pay policy; and information and request to contact the Patient Financial Counselor and Credit/Collection Specialist as soon as possible.

e. Any additional services rendered up to a year after the submission date of an approved Community Care Application will additionally require: updated documentation of non-coverage for the service on the date performed; and a completed MSP Questionnaire indicating the patient's injury is not a compensable injury.
f. Any disputes regarding a patient's eligibility to participate in the Community Care Program shall be directed to the Manager of Business Office/Registration and will be resolved within 10 business days.

  - If it is determined that the patient is ineligible to participate, the number of days spent on dispute resolution shall not be counted toward the minimum 150 days prior to reporting any amount to a credit reporting bureau.

Subject	Community Care Financial Assistance and Discount Payment Program				
Department(s)	Business Office and Compliance				
Reference #	4632				
Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		**Hovlid Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

5. Participant Accounts Maintenance:

A record for each Community Care applicant will be created, and will include the following items:

a. Patient information and application
b. A copy of every correspondence between Orchard Hospital and the participant
c. Detailed bills on all accounts to be included in the application
d. Adjustment form with adjustments taken on accounts
e. Any additional notations and pertinent information

6. Availability of the Community Care Policy:

a. Notice of the Community Care Policy shall be posted clearly posted in locations visible to the public, including but not limited to:
   - Emergency department
   - Billing office
   - Admissions office
   - Other outpatient locations

b. In the event of the hospital providing service to a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, the hospital shall provide a notice to the patient that includes, but is not limited to:

   - A statement of charges for services rendered by Orchard Hospital; and
   - A request that the patient inform Orchard Hospital if the patient has health insurance coverage, Medicare, Medi-Cal or other coverage, and if the patient does not, that the patient may be eligible for such coverage, and can obtain an application for such coverage from Orchard Hospital; and
   - A statement that indicates the patient may qualify for Community Care if they meet the eligibility criteria set forth in this policy; and
   - The name and telephone number of the Patient Financial Counselor and Credit/Collection Specialist from whom the patient may obtain information about the Community Care policy and other assistance policies, and about how to apply for that assistance.

There are no Orchard Hospital providers (contracted or employed) that are prohibited from providing care to FAP eligible patients.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	All Orchard Hospital entities		Medical Specialty Center		Hovlid Community Care Center
	Orchard Hospital		Medical Specialty Center (Oroville)		

REFERENCES:

The processes and procedures described above are designed to comply with CA SB 1276 (Chapter 758, Statutes of 2014), CA AB 774 (Statutes of 2006) and SB 350 (Chapter 347, Statutes of 2007).

Questions regarding SB 1276, AB 774 and SB 350 can be addressed by the Patient Financial Counselor or by California's Office of Statewide Health Planning and Development's website, at

http://www.oshpd.ca.gov/hid/products/hospitals/fairpricing/index.html.
http://aspe.hhs.gov/poverty/14poverty.shtml

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

x	**All Orchard Hospital entities**		**Medical Specialty Center**		**Hovlid Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

2017 HHS POVERTY GUIDELINES – 75% FPL

Persons in Family or Household	75% US Poverty Level
1	$ 9,045
2	$ 12,180
3	$ 15,315
4	$ 18,450
5	$ 21,450
6	$ 24,720
7	$ 27, 855
8	$ 30,990
For each additional person, add	$ 4,180

To determine community care eligibility according to income level:

- Count the number of persons in your family/household

    a. For persons 18 years of age and older, include spouse, domestic partner and dependent children under 21 years of age, whether living at home or not
    b. For persons under 18 years of age, include parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative

- Calculate the household income (annual).

- On the row corresponding to the number of persons in your family/household above, compare your household income to the amount in the column labeled “75% US Poverty Level”

- If your household income is less than 75% US Poverty Level amount, your income supports your eligibility for Community Care.

Subject	Community Care Financial Assistance and Discount Payment Program				
Department(s)	Business Office and Compliance				
Reference #	4632				
Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		**Hovlid Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

To determine community care eligibility according to total monetary assets:

- Calculate your total monetary assets (referred to as “ASSETS” in the equation below)
  - Assets included in retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans **shall not** be included

- Insert total assets into the following equation:
  - (ASSETS – 10,000)/2

- If the remaining amount is less than $5,000, your total asset level supports your eligibility for Community Care.

Subject	Community Care Financial Assistance and Discount Payment Program				
Department(s)	Business Office and Compliance				
Reference #	4632				
Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		**Hovlid Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

2018 HHS POVERTY GUIDELINES - 350% FPL

Household Size	350% US Poverty Level
1	$42,490
2	$57,610
3	$72,730
4	$87,850
5	$102,970
6	$118,090
7	$133,210
8	$148,330
9	$163,450
10	$178,570

To determine Medically Indigent eligibility according to income level:

- Count the number of persons in your family/household
    - For persons 18 years of age and older, include spouse, domestic partner and dependent children under 21 years of age, whether living at home or not
    - For persons under 18 years of age, include parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative
- Calculate the household income (annual).
- On the row corresponding to the number of persons in your family/household above, compare your household income to the amount in the column labeled “350% US Poverty Level”
- If paid medical expenses for medically necessary services exceed 10% of household income in the prior 12 months, then additional expenses beyond that 10% incurred would then be considered eligible for community care.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		**Hovlid Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

Note: Pursuant to AB 774 Sect. 127405(2), Orchard Hospital has established eligibility levels for financial assistance and community care at less than 350 percent of the federal poverty level as appropriate to maintain its financial and operational integrity.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	All Orchard Hospital entities		Medical Specialty Center		Hovlid Community Care Center
	Orchard Hospital		Medical Specialty Center (Oroville)		

DISCOUNT PAYMENT POLICY

POLICY:

Orchard Hospital realizes the need to provide service to patients who cannot otherwise afford health care. This policy applies to all uninsured or underinsured patients who meet the guidelines of this policy and who agree to its terms. A sliding fee schedule based on the annual HHS Poverty Guidelines will be used to determine the qualifying income levels of applicants. Guidelines are subject to change yearly based on the HHS Poverty Guidelines. Understanding this need, the hospital has chosen to fulfill their responsibility to the community by adopting the following Discount Payment Policy.

PROCEDURE:

1. Enrollment Process

- An informal determination of Discount Payment eligibility will be determined by the Patient Financial Counselor and Credit/Collection Specialist, and the applicant may choose to fill out an application based on the recommendation of the Patient Financial Counselor and Credit/Collection Specialist; however, the recommendation of the Patient Financial Counselor and Credit/Collection Specialist is not required in choosing to fill out the Discount Payment Application.

- Upon being submitted for consideration by the Patient Financial Counselor and Credit/Collection Specialist, all properly submitted applications will be reviewed and considered for implementation within 10 business days.

- All applications must be filled out completely and accurately with one of the following required documentation attached, to be considered:

    - Current W-2 withholding form or Income Tax statement form from the previous year, **or**

    - Pay stubs from the previous three months

- Verification of accuracy of application information, including contacting employers for verification of employment, will be made.

Subject	Community Care Financial Assistance and Discount Payment Program				
Department(s)	Business Office and Compliance				
Reference #	4632				
Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		**Hovlid Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

- A letter of either approval or denial will be submitted to each applicant. The letter will contain: the percent discount; adjusted balance (if more than one account, each will be combined into one account for accounting and billing/statement purposes); and the required monthly payment due each month. Also included in the envelope will be a payment schedule and a discount card.

- Updates will be conducted at the end of each calendar year for continued eligibility, or as needed with updated information/changes to guarantor accounts.

2. Discount Payment Account Billing Process, Terms and Settlement

- All accounts will be billed out on a monthly basis.

- Participants are requested to remain current on their outstanding balances. In order to remain current, participants must pay the balance due by the 15th of the following month. If unable to meet these requirements, prior arrangements must be made with the Business Office/Patient Financial Counselor and Credit/Collection Specialist.

- If participant information changes, the participant shall submit changes to the Business Office/Patient Financial Counselor and Credit/Collection Specialist to update their applications or to complete/submit a new application.

- If participant does not pay within 15 days past due, without prior arrangements with the Business Office/Patient Financial Counselor and Credit/Collection Specialist, he/she will be removed from the program.

- Upon removal from the program, a 6-month grace period will be enforced where all amounts will be due and the patient will not be eligible for the program. Accounts on the program will have the discounted amount removed, original balance reinstated minus any payments, and prepared for collections. These accounts will not be considered a part of the new application once the participant is eligible for the program again.

- A new application on new accounts may be submitted after the grace period for consideration.

- Accounts that are removed from the program and that still contain a positive balance after the 6-month grace period will be forwarded to an outside collection agency who will, at their discretion and in accordance with rules and regulations put forth by California Assembly Bill 774, notify credit reporting bureaus. Under no circumstances will an account be reported to a credit reporting bureau under 150 days from the first bill date.

Subject	Community Care Financial Assistance and Discount Payment Program				
Department(s)	Business Office and Compliance				
Reference #	4632				
Scope of Policy (Identifies the entities that are covered under the policy)					
x	All Orchard Hospital entities		Medical Specialty Center		Hovlid Community Care Center
	Orchard Hospital		Medical Specialty Center (Oroville)		

3. Participant Accounts Maintenance

- All accounts will be reviewed monthly for fee adjustments, monthly payments and co-payments
- Notices will be sent for all accounts which are non-compliant.
- Collections efforts may be pursued for accounts that violate the terms set herein.
- In the folder for each application the following items are required:
  - Patient information and application
  - A copy of every correspondence between Orchard Hospital and the participant
  - Detailed bills on all accounts to be included in the application
  - Adjustment form with adjustments taken on accounts
  - Any additional notations and pertinent information

The processes and procedures described above are designed to comply with CA AB 774 (Statutes of 2006) and SB 350 (Chapter 347, Statutes of 2007). Questions regarding AB 774 and SB 350 can be addressed by the Patient Financial Counselor and Credit/Collection Specialist or by California's Office of Statewide Health Planning and Development's website, at http://www.oshpd.ca.gov/hid/products/hospitals/fairpricing/index.html.

REFERENCES:

Pursuant to AB 774 Sect. 127405(2), Orchard Hospital has established eligibility levels for financial assistance and community care at less than 350 percent of the federal poverty level as appropriate to maintain its financial and operational integrity. Mayers Memorial Hospital is a rural hospital as defined in Section 124840.
http://aspe.hhs.gov/poverty/12poverty.shtml

Subject	Community Care Financial Assistance and Discount Payment Program				
Department(s)	Business Office and Compliance				
Reference #	4632				
Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		**Hovlid Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

2018 HHS POVERTY GUIDELINES

Household Size	100% US Poverty Level	150% US Poverty Level	200% US Poverty Level
	80% Discount	60% Discount	40% Discount
1	$12,140	$18,210	$24,290
2	$16,460	$24,690	$32,920
3	$20,780	$31,170	$41,560
4	$25,100	$37,650	$50,200
5	$29,420	$44,130	$58,840
6	$33,740	$50,610	$67,480
7	$38,060	$57,090	$76,120
8	$42,380	$63,570	$84,760
9	$46,700	$70,050	$93,400
10	$51,020	$76,530	$102,040

To determine discount eligibility:

- Count the number of persons in your family/household

   a. For persons 18 years of age and older, spouse, domestic partner 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

- Calculate the household income (annual).
- Sliding across the row corresponding to the number of persons in your family/household above, stop in the first bucket that has an amount greater than the household income
- At the top of that column, the % discount is displayed

REPAYMENT SCHEDULE

Total Patient Responsibility	Maximum Repayment Term	Minimum Monthly Payment
$50 or Less	In Full	In Full
$51 - $100	2 Months	$40
$101 - $300	3 Months	$55
$301 - 4600	6 Months	$75
$601 - $1,000	9 Months	$100
$1,001 - $3,000	12 Months	$150
$3,001 - $6,000	15 Months	$250
$6,000 And Over	18 Months	$350

To determine repayment schedule parameters:

- Establish estimated or calculated total patient charges prior to discount.
  a. The Patient Financial Counselor and Credit/Collection Specialist and/or Department Personnel can provide a list of anticipated charged services and supplies, summed to Total Charges
  b. Per AB 774 Sect 127405(d), the Total Charges amount will be adjusted to mirror the amount of payment the hospital would receive as if it were providing the same services and supplies to Medicare

Subject	Community Care Financial Assistance and Discount Payment Program				
Department(s)	Business Office and Compliance				
Reference #	4632				
Scope of Policy (Identifies the entities that are covered under the policy)					
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	Orchard Hospital		**Medical Specialty Center (Oroville)**		

- Once the total liabilities reflect the amount payable by Medicare, the discount percentage established above will be applied. The resulting amount is “TOTAL PT RESPONSIBILITY” that can be inserted into the table above

- Determine which row applies to your “TOTAL PT LIABILITIES” amount by putting the amount in the appropriate range above.

- Sliding to the right, the repayment of the discounted Total Patient Liabilities must be performed within the corresponding parameters.