## Los Angeles County Department of Health Services

| | | | |
|---|---|---|---|
| **Policy & Procedure Title:** | Principles and Guidelines for Assisting Uninsured Patients | | |
| **Category:** | 500-599 Fiscal & Budget Policy | **Policy No.:** | 515.01 |
| **Originally Issued:** | 2/1/2006 | **Update (U)/Revised (R):** | 1/1/2022 |
| **DHS Division/Unit of Origin:** | Office of Patient Access | | |
| **Policy Contact – Employee Name, Title and DHS Division:** Shari Doi, Director Office of Patient Access | | | |
| **Contact Phone Number(s):** | (213) 288-7802 | | |
| **Distribution: DHS-wide ☒** | **If not DHS-wide, other distribution:** | | |

## PURPOSE:

The purpose of this policy is to adopt principles and guidelines to meet the financial needs of uninsured and underinsured patients receiving services in DHS' facilities.

## POLICY:

The Department of Health Services (DHS) will maintain reduced-cost health care programs for patients who have limited or no financial resources to pay for the medical services received at DHS' facilities.

DHS shall maintain written financial assistance policies for low-income uninsured patients that address both the charity care and discount programs known as "reduced-cost health care plans (RCHCP)". Examples of these RCHCPs include Ability-To-Pay (ATP) and Discount Payment Plan (DPP), both of which are considered the DHS plans for purposes of meeting Health & Safety Code § 127405 requirements, and Pre-Payment.

The ATP financial practice policy shall cover both free and reduced-cost services, for Los Angeles County residents, based on income level. Persons eligible for ATP with income at or below 138% of the federal poverty level (FPL) shall have no liability for the costs of their care and persons eligible for ATP whose income is above 138% FPL shall receive care at a reduced cost.

All uninsured Los Angeles County residents are eligible to apply for ATP. All Out-Of-County/Out-Of-Country/Foreign Visitors and Non-Immigrant Persons treated at a Los Angeles County (County) hospital whose family income is less than or equal to 400% of the FPL are eligible to apply for the DPP. The ATP financial practice policy and DPP policy will set forth the eligibility criteria for reduced-cost or free care. The ATP and DPP policies together shall

ensure that all uninsured or underinsured persons (including those with high medical costs) whose family income is at or below 400% FPL shall be eligible for some form of reduced-cost program for services at a County hospital. Under both ATP and DPP, the liability of a patient whose family income is at or below 400% FPL will be the lesser of the calculated liability, or the amount Medi-Cal would pay for the same service. However, if the amount the Medi-Cal program pays for the service exceeds the facility's charges, the patient liability shall be reduced to 95% of total charges.

Reduced-cost care is also available under ATP to some persons whose income is above 400% FPL.

Facilities will evaluate the patient's eligibility for financial assistance for government sponsored programs, including the Health Benefits Exchange (Covered California).

Notices regarding the availability of financial assistance to low-income and uninsured patients must be posted in visible locations throughout each County hospital including at least Admitting/Registration, Billing Inquiry, Emergency Department, other outpatient settings, observation units, and DHS website.

Every posted notice regarding financial assistance policies must contain brief instructions on how to apply for assistance under the RCHCP. The notices must also include a telephone number that can be used to obtain additional information.

DHS shall provide patients with a written notice that contains information about availability of the hospital's ATP, and DPP programs, including summary information about eligibility, as well as contact information for a facility employee or office from which the person may obtain further information about these programs.

DHS shall provide patients with an appeal process to submit in writing when the patient or patient's representative disagrees with the determination of their financial assistance eligibility.

Facilities shall provide Medi-Cal applications to all patients who either indicate no third-party coverage or apply for ATP or DPP as persons with high medical costs before discharge or departure from the hospital.

Facilities must ensure that appropriate staff members are knowledgeable about the existence of DHS' RCHCP. Training on these programs will be provided to staff members who directly interact with patients regarding their medical bills (e.g., billing inquiry office, financial department, etc.).

Facilities must make their best efforts to ensure RCHCP are applied consistently.

Facilities should communicate information to the patient regarding financial assistance policies in the preferred language of the patient or his/her family, if reasonably possible, and in a manner consistent with all applicable federal and state laws and regulations, as well as County policy.

DHS will share their financial assistance policies with appropriate community health and human services agencies and other organizations that assist such patients.

DHS will ensure that contracted vendors are knowledgeable about the DHS financial assistance policies and aware of their obligation to make the RCHCP available to qualified patients.

DHS shall make available an extended payment plan which is interest free to persons with a financial liability (see FP 520.27).

DHS will have written policies regarding when and under whose authority patient debt is advanced for collection. DHS will use its best efforts to ensure that patient accounts are processed fairly and consistently (see FP 530.08 – Referral of Delinquent Inpatient Self-Pay Accounts to Outside Collection Agencies and FP 530.14 – Referral of Delinquent Outpatient Self-Pay Accounts to Outside Collection Agencies).

DHS will have policies on the standards and practices for the collection of debt and shall require all contracted collection agencies to comply with those policies.

DHS may obtain and retain the written policies from contracted collection agency vendors regarding collection practices to ensure compliance with the county policies. DHS shall require its contracted billing agents and contracted collection agencies to provide all legally required notices to patients, and to comply with the County's definition and application of a reasonable payment plan.

**GUIDELINES:**

It is the responsibility of any patient seeking financial assistance from the facility (or the patient's legal representative) to provide the facility with information concerning health benefits coverage, financial status and any other information that is necessary for the facility to make a determination regarding the patient's eligibility under any RCHCP or government-sponsored programs and the amount of his or her liability under the RCHCP. The DHS facility will inquire of every patient regarding the existence of any possible applicable health care coverage.

DHS' RCHCP financial practices must allow a reasonable period for the patient to submit the information necessary to determine eligibility.

At the time of billing, facilities and outside vendors shall provide to all low-income uninsured patients at least the same information concerning services and charges as is provided to all others in the same financial class. Bills to uninsured patients shall include all legally required information, including information about possible eligibility for government sponsored programs and about applying for government sponsored programs including coverage from the California Health Benefit Exchange or RCHCP. Note: DHS facilities do not itemize bills. A series of bills (data mailers) are sent.

The facility or outside collection agency operating on behalf of the facility shall not, in dealing with low-income or uninsured patients, use wage garnishments as a means of collecting unpaid bills. This requirement does not preclude facilities or its contracted agency from pursuing reimbursement from third-party liability settlements, tortfeasors, or other legally responsible parties.

## REFERENCE(S)/AUTHORITY:

CROSS REFERENCES:

DHS Policy Nos.:

318 Non-English and Limited English Proficiency
515 Registration/Financial Screening
516 Non-Emergency Medical Care Services Requirements – Los Angeles County Patients
516.1 Non-Emergency Medical Care Services Requirements – Out-of-County and Out-of-Country/Foreign Visitor and Non-Immigrant Persons
520 Charging and Collecting Requirements for Medical Care Services Rendered530 Collections

Financial Practice Policy Nos.:

515.01 Inpatient Admission and Discharge Procedures Related to Patient Financial Screening
520.15 Ability-To-Pay Plan Verification Guidelines
520.26 Pre-Payment Plan
520.27 Extended Payment Plan
520.28 Discount Payment Plan (DPP) Guidelines
530.08 Referral of Delinquent Inpatient Self-Pay Accounts to Outside Collection Agencies
530.14 Referral of Delinquent Outpatient Self-Pay Accounts to Outside Collection Agencies

California HealthCare Association - Voluntary Principles and Guidelines for Assisting Low-Income Uninsured Patients

Etter Consent Decree Flyer – You Can Get No-Cost or Low-Cost Medical Care at Any LA County Clinic or Hospital, 4/14

OFFICE OF PATIENT ACCESS
PFS ADMINISTRATION

# ABILITY TO PAY (ATP)
# PROGRAM & PROCEDURE GUIDE

## Introduction

The *goal* of the Ability to Pay (ATP) Program & Procedure Guide document is to provide detailed program policy and a structured procedure outline on what is the *Ability to Pay Program* and how it is initiated and completed. This is intended for Patient Access and Patient Financial Services staff to use. This guide is designed to set "the rules" in plain language and consolidate the Patient Financial Services Memos and Financial Practices.

This document is aligned with the *Patient Access Principles* of Patient Centered, Visit Ready, and Revenue.

The Ability to Pay Program & Procedure Guide was developed by PFS Administration staff and approved by Shari Doi, Director, Office of Patient Access. The document was discussed and reviewed with:

- Office of Patient Access (OPA) Administration
- PFS Managers
- OPA Coverage Verification workgroup
- OPA ED/UCC Workgroup

## Point of Contact

For any questions, suggestions, comments, etc. please direct them to PFSAdmin@dhs.lacounty.gov.
Visit Office of Patient Access-PFS website to access more helpful resources.

Note to reader: 125% zoom or higher is recommended for optimal viewing of this PDF document.

Published Version 3 in July 2022
Published Version 2 in March 2022
Published Version 1 in November 2021

Health Services
LOS ANGELES COUNTY

# Table of Contents

**Policy Overview ..... 2**

- Covered Services/Benefits ..... 3
- Automatic Ability to Pay (Auto ATP) ..... 3
- ATP Liability ..... 3
- Eligibility Criteria: ..... 4
  - Residency: ..... 4
  - Required Verification: ..... 4
  - Income and Resource (property) Limits: ..... 5

## Policy Overview

Ability to Pay is a No-Cost/Low-Cost program available for uninsured Los Angeles (LA) County residents to help cover the cost of medical services received at LA County DHS facilities. The duration of the ATP Services Agreement is one (1) year from the first day of the month of application for all inpatient and outpatient services received during a period of twelve (12) months. LA County patients, who utilize LA County DHS facilities and are not eligible for Medi-Cal benefits or do not have third party coverage may qualify and apply for ATP[1]. The ATP program can be completed in-person or telephonically with a patient/responsible relative under penalty of perjury. Patients should be screened for potential Medi-Cal eligibility using the Medi-Cal Linkage Referral Checklist[2] by non-Medi-Cal eligibility staff. If potentially eligible, should fully cooperate with the Medi-Cal application process before an ATP application can be initiated. Patients with a household income at or below 138% Federal Poverty Level (FPL) will have no ATP liability. Patients with a household income above 138% FPL will have an ATP liability based on the income sliding scale.

Patients' accounts/visits that have a valid ATP without Liability should be coded with the 350 insurance code; ATP with liability should be coded with the 351 insurance code.

- If determined Medi-Cal eligible, Medi-Cal will be the primary insurance for the services.
- If determined ineligible for Medi-Cal for reasons other than failure to cooperate, patient should be evaluated for ATP if residency requirements are met.
- If there is no cooperation with Medi-Cal and/or ATP, then patient will be liable for charges.
- Patients can reapply for ATP if their current liability period is coming to an end. Staff should reevaluate for Medi-Cal using the Medi-Cal Linkage Referral Checklist during each ATP program reapplication.
- If during the ATP eligibility period, it is determined that the patient becomes newly eligible for Medi-Cal due to income change in circumstances, i.e., income change or disability, then the ATP Services Agreement will be null and void as of the effective date of Medi-Cal eligibility.
- If during the eligibility period, the financial condition of the patient changes, and this either increases or decreases the ATP liability amount, the patient must once again satisfy all ATP Services Agreement requirements. Two new ATP Services Agreements must be completed and signed under penalty of perjury; one to cover the previous effective dates (partial 12-month period) until the income change took place, and the second one's effective dates (new 12-month period) to reflect the new income change start month.

ATP applications can be made retroactively with no time limitation. However, eligibility and liability will be based on the rules and FPL in existence for the retroactive period. The ATP program uses the corresponding FPL and rules based on the date of service entered into the system.

The Terms and Conditions along with the ATP Services Agreement should be printed and provided to the patient for their records. The Terms and Conditions provides detail about the services, eligibility, length

[1] Refer to the **Covered Services/Benefits** section for further details.
[2] Medi-Cal Linkage Referral Checklist can be used to determine potential eligibility for Medi-Cal by non-Medi-Cal eligibility workers.

of eligibility service agreement, ATP liability amount, third party liability, and appeals. Inform the applicant/patient that if they dispute their ATP liability amount and/or eligibility determination, they may request a review at the supervisory level within 10 days by completing and submitting the ATP Liability/Eligibility Appeals Request Form[3].

## Covered Services/Benefits

- Inpatient, outpatient, and emergency services at all DHS facilities that are medically necessary.
- Tests and medications.
- ATP excludes coverage for non-medically necessary cosmetic surgery.
  - Exception:
    - Medically necessary reconstructive surgery, such as cancer-related breast reconstruction is covered.
- ATP excludes coverage for infertility-related services.
- ATP may be used to cover services not covered by Medi-Cal, Medicare, or private insurance.
  - ATP may cover patient's deductible/co-insurance for private insurance, but it does not cover Medicare deductibles and co-insurances.
- ATP does not cover Medi-Cal Share of Cost (SOC).

## Automatic Ability to Pay (Auto ATP)

- Auto ATP will apply to patients that are eligible for Restricted Medi-Cal benefits with no SOC for inpatient or outpatient uncovered services if LA County residency requirements are met. Patients who are covered by Restricted Medi-Cal with no SOC and are LA County residents will be concurrently covered by ATP without having to complete and sign an ATP Service Agreement.
- There is no need to assign a 350 insurance code in the secondary or tertiary position for services not covered by Restricted Medi-Cal with no SOC. The accounts will be adjusted as ATP by the Billing Office.
- Patients who are covered by Restricted Medi-Cal benefits with a SOC will have to continue to apply and complete the ATP Services Agreement to determine their ATP liability amount for services not covered by Restricted Medi-Cal.

## ATP Liability

Each ATP contract liability may vary depending on household size and income. The household income information will be displayed in the Income Calculation and Liability Determination Worksheet[4]. Refer to the PFS Memo, Ability to Pay Program Inpatient and Outpatient Services Liability Chart that is annually published reflecting the new FPL and liability amounts and its income-based sliding scale. Explain the ATP liability amount to the patient.

[3] To request an appeal, the patient or patient's representative must complete the proper sections and return the form to the ATP Interviewer's Supervisor within 10 days of receiving it. The supervisor will review the received Appeals form to reevaluate the ATP Services Agreement's liability amount and/or eligibility criteria; then complete the *Supervisor's Review/Response* section with the findings and reply to the patient within 10 days of receiving the Appeals form.

[4] Income Calculation and Liability Determination Worksheet captures all patient's household *Income Calculation* from the data system.

| FPL % | Outpatient ATP Liability per Month | Inpatient ATP Liability per Admission |
|---|---|---|
| 0 - 138 | $0 | $0 |
| 139 - 200 | $90 | $500 |
| 201 - 300 | $170 | $1,000 |
| 301 - 350 | $240 | $1,500 |
| 351 - 400 | $285 | $2,000 |
| 401 - 500 | $355 | $2,500 |
| 501 - 600 | $435 | $3,000 |
| 600 + | $485 | $3,500 |

- *Outpatient* ATP liability will be monthly if services have been rendered regardless of the number of visits in the month.
- *Inpatient* ATP liability is per admission regardless of the length of stay.
- If the household income is at or below 138% FPL, then patient is eligible for a $0 liability for inpatient/outpatient services.
- If the household income is above 138% FPL, then patient is eligible for a liability amount for inpatient/outpatient services based on the annually revised FPL ATP liability chart.
- The applicant/patient has the option to make payments for their liability via an Extended Payment Plan agreement. The Extended Payment Plan agreement will allow the patient to make ATP liability payments over time.
- The ATP liability amount may be corrected retroactively if there was an administrative error.

## Eligibility Criteria:

### Residency:

- Must be LA County resident
- Legal residency not required; however, refer to PFS Memo 34-21 for a list of qualified LA County non-citizen residents.
  - Patients with active Visas are ineligible for ATP
  - Patients with valid Work Permits are also ineligible except for certain Category Code holders.

### Required Verification:

- Address
  - Refer to DHS Policy 515.1 Patient Address Verification for examples of address verifications that confirm current address.
  - Address Verification Affidavits
    - If address verification is unavailable, the patient my sign an Affidavit of Residency or Identity per the DHS Policy 515.1 Patient Address Verification.

- Declaration of income (Income verification is not required at the time of application; however, if audited, income and income deductions are subject to verification, i.e., paystubs, income tax returns, disability/unemployment insurance benefits, affidavit, etc.)
- Cooperation in determining non-eligibility to Medi-Cal

## Income and Resource (property) Limits:

- No income limits
- Resources are not counted

# DISCOUNT PAYMENT PLAN (DPP) PROGRAM & PROCEDURE GUIDE

## Introduction

The *goal* of the *Discount Payment Plan (DPP) Program & Procedure Guide* document is to provide detailed program policy and a structured procedure outline on the DPP Program and how it is initiated and completed. This is intended for Patient Financial Services staff to use at the four (4) DHS hospitals and hospital-based clinics only. This guide is designed to set "the rules" in plain language and consolidate the Patient Financial Services Memos and Financial Practices.

This document is aligned with the *Patient Access Principles* of Patient Centered, Visit Ready, and Revenue.

The Discount Payment Plan (DPP) Program & Procedure Guide was developed by PFS Administration staff and approved by Shari Doi, Director, Office of Patient Access. The document was discussed and reviewed with:

Office of Patient Access (OPA) Administration
PFS Managers

## Point of Contact

For any questions, suggestions, comments, etc. please direct them to PFSAdmin@dhs.lacounty.gov. Visit Office of Patient Access-PFS website to access more helpful resources.

Published Version 1 in September 2022

Health Services
LOS ANGELES COUNTY

# Discount Payment Plan (DPP)
# Program & Procedure Guide

## Table of Contents


**Policy Overview ..... 2**

- Covered Services/Benefits ..... 2
  - DPP covered services/benefits ..... 2
- DPP Liability/Cost ..... 2
- Eligibility Criteria ..... 3
  - Residency ..... 3
  - Income and Resource (property) Limits ..... 3
  - Required Verifications ..... 3

## Policy Overview

Out-Of-County/Out-Of-Country (OOC) and foreign visitor patients treated at the four (4) Los Angeles (LA) County Department Health Services (DHS) hospitals who are uninsured, underinsured, or have high medical costs[1] are eligible to apply for the **Discount Payment Plan (DPP)** if their household gross income is less than or equal to 400% of the Federal Poverty Level (FPL) to reduce their cost of care. Patients should be screened for potential Medi-Cal eligibility using the Medi-Cal Linkage Referral Checklist[2]. If potentially eligible, patients should be advised to fully cooperate with the Medi-Cal application process. To be eligible for DPP, the patient must be uninsured and ineligible for the Ability to Pay (ATP) Program or have services that won't be covered by Medi-Cal, Medicare, private insurance or other healthcare coverage. Each Inpatient admission requires a separate Discount Payment Plan (DPP) Agreement form. Outpatient services received in DHS hospital-based clinics require a DPP Agreement form for an annual period (12 months); a single agreement may be made for all outpatient services received during a single 12-month period.

- OOC and foreign visitor patient encounter(s) should be coded with insurance code 501 prior to the self-pay insurance code (000 or 469).
  - Once the patient is interviewed and the DPP Agreement is initiated, add insurance code 484 before the insurance code 501 for the corresponding encounter(s) (ex. 484/501/000 or 469).

## Covered Services/Benefits

DHS maintains Reduced-Cost Health Care Programs (RCHCP) for patients who have limited or no financial resources to pay for their medical services received at DHS facilities[3].

### DPP covered services/benefits

- Reduces the cost of care for patients that receive either inpatient, outpatient, or emergency medical care services[4] that are medically necessary at any DHS hospital or DHS hospital-based outpatient clinics.

## DPP Liability/Cost

- Refer to the PFS Memo entitled: "Maximum Liability for Discount Payment Pan (DPP) Patients with Income at or below 400% FPL", that is published annually reflecting the new FPL and gross family monthly income maximums.
- The patient's liability amount shall not be greater than the amount the facility would receive from the Medi-Cal program for the same service to a Medi-Cal eligible patient. If the amount

[1] High medical cost is defined as the annual out-of-pocket costs incurred or paid by the patient or the patient's family that exceeds 10% of the patient's family income in the prior 12 months.
[2] Medi-Cal Linkage Referral Checklist can be used to determine potential eligibility for Medi-Cal by non-Medi-Cal eligibility workers.
[3] Refer to Policy 515.01 Principles and Guidelines for Assisting Uninsured Patients for more details.
[4] Refer to Policy 516 Non-Emergency Medical Care Services Requirements – Los Angeles County Patients to review the emergency medical care services and non-emergency medical care services definitions for better understanding.

the facility would receive from the Medi-Cal program exceeds charges, the patient's liability amount shall not be greater than 95% of the patient's undiscounted liability amount.

- Contact the Centralized Billing Office (CBO) to verify that you are using the most current Medi-Cal reimbursement rate for your facility for the corresponding date of service.
  - Inpatient admission services liability amount is calculated per day for each inpatient stay of admission.
  - Outpatient services liability amount at hospital-based clinics are calculated for each outpatient visit during the DPP Agreement period.

## Eligibility Criteria

### Residency

- Non-LA County residents
  - Most persons with a temporary unexpired visa, or an Employment Authorization Document (i.e., work permit), are considered to be Out-of-County/Out-of-Country/Foreign Visitor (OOC/OOC/FV) and are ineligible for any LA County No-Cost/Low-Cost programs, with the exception of the DPP[5].

### Income and Resource (property) Limits

- Household gross income must be less than or equal to 400 % FPL.
- Resources (property) should not be counted.

### Required Verifications

- Identity verification[6]
- Address[7]
- Income
  - All income received by the household members must be reported (income type, amount received, and the frequency in which income is received) for the month that the services were received.
  - Examples of acceptable verification of income include: 1. Check stubs for earned or unearned income; 2. Federal Income Tax Return; 3. Signed statement from the person or organization providing the income; 4. Award letter.
  - The following *Income exclusions* should be documented on the DPP Income Calculation and Eligibility Determination Worksheet's Interviewer's Comment section and include the applicant's written statement:
    - Earned income of children

[5] Refer to PFS Memo 34-21 Residency Guidance to Qualify for the Los Angeles County's No-Cost/Low-Cost Programs.
[6] Refer to DHS Policy 370.1 Patient Identity Verification
[7] Refer to DHS Policy 515.1 Patient Address Verification

- Earned income of children under 14 years of age.
- Earned income of children 14-18 years of age who are attending school full time should be excluded.

  Note: The parent's statement that the income is from earnings and that the child is a full-time student is acceptable verification that must be documented on the DPP Agreement.

- Educational grants which are specifically for educational purposes can be exempt. The portion that is for housing, food, utilities should be counted as income. Education loans which are required to be repaid should be excluded.
- General Relief (GR) or Cash Aid from another County should be excluded income.

▪ Income Deductions:

a. If household gross income is at or below 400% FPL, the patient is eligible for the DPP. There is no need to include *income deductions*.
b. If household gross income exceeds 400% FPL, allow income deductions for *inpatient services only*.
   1. $90 work expense allowed for each employed person regardless of hours of employment.
   2. Work-related expenses: child-care is an allowable deduction provided that both parents are employed, or one parent is employed and the other one is unable to provide childcare due to incapacity/disability.
   3. Business expenses for self-employed individual
   4. Expenses of rental property income
      - Monthly paid interest, property taxes, insurance, utilities, and upkeep/repairs.
   5. Child/spousal support
   6. Medical insurance premiums

❖ If no income is reported, a written statement from the patient is required as to how the household's needs are being met.

❖ Affidavits may be used to substitute as acceptable verification of information provided by a person who is cooperating fully in the application process.

❖ The DPP Agreement and ORCHID New Person Comment field should be documented to show the reason why an affidavit is being used in lieu of other documents to verify required items and what attempts were made to secure more appropriate verification.