

**HUNTINGTON HOSPITAL  
ADMINISTRATIVE POLICY & PROCEDURE**

<b>SUBJECT:</b> <b>FINANCIAL ASSISTANCE POLICY</b>	<b>POLICY NO: 329</b>	<b>PAGE 1 OF 17</b>
<b>AUTHORIZED APPROVAL:</b> Lisa Maqueira	<b>EFFECTIVE DATE:</b> 01/01/2024	<b>SUPERCEDES/ REPLACES</b> <b>Financial Assistance Policy 2023</b>

**I. PURPOSE:**

- a. Pasadena Hospital Association, Ltd., dba Huntington Hospital and The Huntington Medical Foundation dba Huntington Health Physicians (together, the “Organization”) is committed to meeting the health care needs of all patients in the community and based on the following principles:
  - i. Treating all people equitably, with dignity, respect and compassion;
  - ii. Serving the emergency health care needs of all, regardless of a patient’s ability to pay; and
  - iii. Assisting patients who cannot pay for part or all of the care they receive.

This Policy demonstrates the Organization’s commitment to our mission, vision and principles by helping to meet the needs of the low-income uninsured patients and the underinsured patients in our community. As part of fulfilling this commitment, the Organization provides medically necessary services, without cost or at a reduced cost, to patients who qualify under this Policy.

- b. This Policy provides guidelines for identifying patients who may qualify for financial assistance and establishes the financial screening criteria to determine which patients qualify for financial assistance.

**II. POLICY:**

- a. **Definitions.** Capitalized terms used in this Policy are defined in the “Definitions” section at the end of this Policy or when first used.
- b. **Covered Under this Policy.** Only services provided directly by the Organization will be covered by this Policy. Physician services are only included if provided by Huntington Aligned Medical Group (“HAMG”) and Huntington Foundation Medical Group (“HFMG”). It excludes the Organization’s Randall Breast Center locations, Huntington Ambulatory Surgery Center, LLC and Huntington Outpatient Imaging Centers, LLC.
- c. **Facilities, Physicians and Other Providers Not Covered by this Policy May Have Separate Financial Assistance Policies.** Community members of the Organization’s Medical Staff (i.e., providers that are not part of the Organization) may also make financial assistance available to their patients. The Organization will make available, upon request, a list of information it has regarding these physicians indicating whether specific physicians (or their medical group) will: (i)

provide equivalent discounts from the physician's professional fees to low-income uninsured patients as the Organization provides, based on the criteria set forth in the Policy; (ii) accept the Organization's determination of a patient's eligibility for financial assistance; and (iii) comply with all applicable federal, state and local laws, regulations, ordinances and orders with respect to the collection of consumer debt accounts. The Organization will not be responsible for such physicians' administration of financial assistance programs or their billing practices.

d. **Help Paying Your Bill - Eligibility Criteria**

- i. **Financial Assistance.** Full Financial Assistance will be made available to patients whose family income and assets are at or below 400 percent of the current year's FPL. Patients whose income ranges between 401 to 600 percent of the FPL also qualify for discounted care. Even though assets are included in the financial assistance application ("Application"), they will not be considered in determining eligibility for discounts. Attachment B sets out the ranges for financial assistance available from the Organization.
- ii. **Pre-Service Patients (Elective/Non-Emergent Care).** Patients scheduled as elective inpatients or scheduled as non-emergent outpatients require prior approval for financial assistance by the Financial Assistance Coordinator or their designee. Only medically necessary procedures are eligible for approval. Financial assistance for elective procedures and for follow-up care following discharge is limited to patients who live in the Organization's service area or as otherwise approved by the Financial Assistance Coordinator or their designee. The Organization retains the right to prospectively not grant financial assistance in connection with a patient's proposed non-emergency and other non-medically necessary care based on the need of the Organization to judiciously allocate its financial and clinical resources.
- iii. **Additional Financial Resources and Required Patient Cooperation.** Patients approved for assistance under this Policy agree to continuously cooperate in the process needed to obtain reimbursement for the Organization's services from third party sources such as the California Victims of Crime funds, the County Trauma Program, the Medi-Cal program, and health plans that offer coverage through the California Health Benefit Exchange (the "Exchange"). A patient's application for third party coverage for the patient's health care costs shall not preclude eligibility for assistance under this Policy. A patient shall, as a condition of financial assistance, apply for coverage under Medi-Cal, Healthy Families, and the County Trauma Program as applicable and, where appropriate, coverage under the Exchange. The foregoing shall also apply to patients residing out of state and their application for Medicaid within their state.

The Organization will make appropriate referrals to local county agencies including Healthy Families, Covered California, Medi-Cal or other programs to determine potential eligibility.

The Organization shall be entitled to bill any third-party insurer providing coverage to a patient, including any source of third-party liability. Health insurers and health plans are

prohibited from reducing their reimbursement of a claim to the Organization even if the Organization has waived all or a portion of a patient's bill pursuant to this Policy.

- iv. **Self-Pay Patients.** The Organization has made an assumption based on its historical experience and the current insurance environment that patients who lack insurance are not able to afford insurance. The Organization presumes that these patients are eligible for financial assistance programs and will make the following assistance available to all such patients unless the patient makes other arrangements for services provided by the Organization. The discounted amount, not billed to the patient, is uncompensated care that will be reported by the Organization consistent with guidelines in the Centers for Medicare & Medicaid Services' Provider Reimbursement Manual, chapter 15-2, section 4012.
  - 1. Self-Pay patients will automatically be billed at a discounted amount for the Organization (See Attachment C).
  - 2. Self-Pay patients are eligible for these discounts without submitting an Application. This financial assistance does not extend to elective procedures unless a specific agreement is made between the Organization and the patient.
- v. **Medically Indigent Patients (Not Otherwise Eligible for a Discount).** Patients who are Medically Indigent but who are not otherwise eligible for financial assistance under this Policy may still request financial assistance in accordance with the process set forth in this Policy. The request for financial assistance due to Medical Indigency must be approved by the Financial Assistance Coordinator, or their designee, in their discretion.
- e. **Financial Assistance Administration.** The Organization utilizes a single, unified patient Application for financial assistance. The process is designed to give each applicant an opportunity to receive the maximum financial assistance benefit for which they may qualify. Any patient who requests financial assistance will be asked to complete an Application.
  - i. **How to Apply.** The Application process can be initiated by the patient or any staff member of the Organization by contacting: Self Pay, Customer Service at (323) 866-8600.

This process includes the following:

- 1. Patients are provided with the Application, a Medi-Cal Application and information on Credit Counseling.
- 2. Applicants are offered assistance in completing the forms by the following departments: Self Pay, Customer Service, Registration, Admitting, and ED.
- 3. The Application may be completed orally with assistance from Organization staff but will still require a patient or representative to sign the Application.

## ii. Reviewing Application

1. **Determination.** Eligibility guidelines are calculated using the current FPL as the measure of eligibility.
2. **Determinations by Affiliates and Approved Community Partners.** Patients who have recently had financial assistance applications approved by certain affiliates or Community Partners of the Organization, may be approved on an expedited basis by the Organization, at the Organization's discretion. The Organization will advise patients applying for financial assistance if such expedited approval is available.
3. **Assets.** The consideration of assets in determining eligibility is limited to the definition in this Policy.
4. **Income** for partial periods shall be included in worksheets using annualized data.
5. **Deductions.** Other financial obligations including living expenses and other items of reasonable and necessary nature will be considered.
6. **Patient Maximum Out-of-Pocket Expense.** Any payment from a patient for services covered by this Policy shall be limited to no greater than the AGB.
7. **Reevaluation.** Eligibility may be reevaluated by the Organization if any of the following occur:
  - a. Patient income changes.
  - b. Patient family size changes.
  - c. A determination is made that any part of the financial assistance Application is false or misleading, in which case the initial financial assistance may be retroactively denied.

- iii. **Submitting Required Documentation.** The Organization requests various documents from patients applying for financial assistance in order to substantiate their eligibility. The documents may include, but are not limited to, the following:
1. Completed Application.
  2. Income documents may include:
    - a. Current period payroll check stub,
    - b. Prior year's tax return, or
    - c. Written explanation.
  3. Asset documents may include:
    - a. Copies of prior month's bank statement (all pages),
    - b. Money Market account statements,
    - c. Stocks,
    - d. Bonds,
    - e. Certificate of Deposits,
    - f. Brokerage accounts (excludes documents pertaining to retirement plans, deferred compensation plans (both qualified and nonqualified under the IRS code)), and
    - g. Unemployment, Social Security benefits, or Disability benefits stub.
- iv. **Submitting Completed Application.** If a patient submits a completed Application, during the Application Period, then the Organization shall:
1. Immediately take all reasonably available measures to suspend or reverse any ECAs taken against the patient to obtain payment for the care. Such reasonably available measures generally include, but are not limited to, advising collection agencies to cease collection activities, measures to vacate any judgment against the patient, lift any levy or lien on the patient's property, and remove from the patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.
  2. Make a determination on eligibility or identify if Application is incomplete or requires additional information, within a reasonable time.
  3. Promptly notify the patient in writing of the eligibility determination, including, if applicable, the assistance for which the patient is eligible and the basis for the determination.
  4. If the patient is eligible for financial assistance, then the Organization shall notify the patient in writing of eligibility, available assistance, the basis for determination and the service dates covered.
    - a. If there is no patient responsibility, then no further steps are required other than refunding amounts paid as provided in the "Refunds" section. If

there is a remaining balance, then the Organization shall also notify the patient in writing, the amount the patient owes for care and describe how the patient can get additional account information.

- b. Once a patient is approved for financial assistance, the patient will not be charged more for emergency or other medically necessary care than the AGB.

Approvals of eligibility may only be made by individuals specifically authorized by the Organization. This individual currently is the Vice President, Finance and Chief Revenue Cycle Officer or their designee.

- v. **Determination Letter.** After a patient submits a complete application and submits the required documentation, the Organization will send a letter to indicate the determination of approval or ineligible. The letters will include the following:
  - 1. A clear statement of the determination for patient's eligibility for financial assistance.
  - 2. If the patient was ineligible for financial assistance, a clear statement explaining why the patient was denied.
  - 3. If the patient was ineligible due to a service that was not medically necessary, the attending physician of the service will have attested to this prior to the denial.
  - 4. If the patient was approved for financial assistance, a clear explanation of the reduced bill and instruction on how the patient may obtain additional information regarding a reasonable payment plan, if applicable
  - 5. Contact information for the Organization, including department, contact name and where the patient may appeal the hospital decision.
  - 6. Information on the Department of Health Care Access and Information's (HCAI) Hospital Bill Complaint Program.
  - 7. Information on the Health Consumer Alliance.
- vi. **Patients with Limited Information for Application.** The absence of patient financial data available to the Organization does not preclude eligibility for financial assistance. In evaluating all factors pertaining to a patient's clinical, personal and demographic situation, and alternative documentation (including information that may be provided by other charitable organizations), the Organization may determine a patient is eligible for financial assistance by making reasonable assumptions regarding the patient's income.
- vii. **Incomplete Application.** If a patient submits an incomplete Application, then the Organization shall promptly provide the patient with a written notice that describes the additional information and/or documentation required for the Application and include contact information for Application processing. If the patient subsequently completes the Application with required information during the Application Period (or such longer

period of time as elected by the Organization), then the Application will be considered complete.

- viii. **Incomplete Application Completed.** If a patient who has submitted an incomplete Application during the Application Period subsequently completes the Application, within a reasonable timeframe given to respond to requests for additional information and/or documentation, then the patient will be considered to have submitted a completed Application, and the Organization will have made reasonable efforts to determine whether the patient is eligible only if it takes the other steps required by this Policy with regard to completed Applications.
- ix. **Anti-Abuse Rule for Applications with Questionable Information.** The Organization shall not make determinations that a patient is not eligible for financial assistance based on information it has reason to believe is unreliable or incorrect or on information obtained from the patient under duress or through the use of coercive practices. A coercive practice includes delaying or denying emergency medical care to a patient until the patient has provided information requested to determine whether the patient is eligible for financial assistance for the care being delayed or denied.
- x. **Handling of Incomplete Applications.** The Organization may consider a patient's failure to provide reasonable and necessary documentation in making its financial assistance determinations. However, the Organization will act reasonably and make the best determination it can with the available information.
- xi. **Presumptive Eligibility.** The Organization may determine that the patient is eligible for financial assistance for the current services based on information it has obtained or assessed without looking to the patient to provide all information required by the usual Application process or the fact that the patient has no health insurance. The Organization's determination may include reliance on a prior determination by the Organization, information provided by another provider of the patient, or a general assessment of information available to the Organization's staff. In such cases, the Organization shall (a) notify the patient of the basis for the presumptive eligibility determination and the manner in which the patient may apply for more generous assistance available under the Policy; (b) give the patient One Hundred Twenty (120) days to apply for more generous assistance; and if the patient submits a complete Application seeking more generous assistance, then determines whether the patient is eligible for a more generous discount and takes the other steps required by this Policy with regard to completed Applications. Self-Pay patients receiving discounts described in this Policy shall receive such notice by means of the Plain Language Summary (see Attachment A) printed on their statements.
- xii. **Patient Waivers Do Not Relieve the Organization of Obligation to Undertake Reasonable Efforts.** Obtaining a verbal or written waiver from a patient, such as a signed statement that the patient does not wish to apply for assistance under the Policy or receive the information to be provided to patients under this Policy, will not itself constitute a determination that the patient is not eligible and will not satisfy the

requirement to make reasonable efforts to determine whether the patient is eligible before engaging in ECAs against the patient.

- xiii. **Payment Plans.** When a patient is determined eligible for financial assistance and a balance remains, then they shall have the option to pay through a scheduled term payment plan. The Organization will discuss plan options with the patient and develop term payment plans that generally last no longer than twelve (12) months and are interest free. See the Organization's Debt Collection policy for additional details.
- xiv. **Dispute Resolution.** In the event a dispute arises regarding qualification for financial assistance, the patient may submit a written appeal for reconsideration with the Organization. The written appeal should explain the rationale for dispute and include supporting documentation. The Organization's Manager of Customer Service and Operations will promptly review the appeal and provide the patient with a written determination. In the event the patient believes a dispute remains after the first appeal, the patient may request in writing, the Organization's Vice President, Finance and Chief Revenue Cycle Officer or their designee shall review and provide a final written determination.
- xv. **Confidentiality of Application Information.** The Organization shall maintain all information received from patients requesting eligibility under this Policy as confidential information. Information concerning income and Assets obtained as part of the Application and approval process shall be maintained in a file that is separate from information that may be used to collect amounts owed.
- xvi. **Time Period for Completion of Application (the "Application Period").** Patients shall be given Two Hundred Forty (240) days to complete an Application. The Application Period begins on the date care that is subject to the Application was first provided (using the commencement of the last course of treatment if multiple dates of service are applicable).

f. **Term**

- i. The initial financial assistance for Financially Qualified Patient's approval is valid for a period of six (6) months from the date the Application was complete. Eligibility may be reassessed, upon patient request, at the end of the initial approval period. At the Organization's election, a new six (6) month approval period may be authorized without a new Application. After twelve (12) months, a new Application must be completed by the patient. Starting with the date the final Application is approved, open, qualified accounts will be written-off to financial assistance based on the level of assistance



granted. On a go-forward basis, qualified accounts for the next six (6) months would be eligible for financial assistance write-off.

**g. Notices, Written Communications and Statements**

- i. The Organization provides the following notices and information regarding financial assistance:
    1. This Policy.
    2. A Plain Language Summary of the Policy. The Plain Language Summary shall be a clear, concise, and easy to understand document that notifies patients and other individuals that the Organization offers financial assistance under this Policy. The Plain Language Summary shall be drafted in a manner that sets out relevant information including the information required by state and federal laws such as the eligibility requirements and assistance offered under this Policy, a brief summary of how to apply for assistance under this Policy, and information for obtaining additional information and assistance, including copies in other languages.
    3. The Application.
    4. The Organization's Debt Collection Policy.
  - ii. These materials shall be made available in a variety of ways including:
    1. **Website.** The Financial Assistance Policy, the Financial Assistance Application, and a Plain Language Summary of the Financial Assistance Policy are located on this Organization's website. Links to such materials shall also be posted on the Website.
    2. **Email or Paper Copies.** Copies of any of the materials referenced in this Policy may be obtained by making a request to Self Pay, Customer Service at (323) 866-8600.
    3. **Posted Signage.** The Plain Language Summary shall be posted in the following locations: the Emergency Department, the Admitting Department, the Billing Department, centralized and decentralized registration areas and other outpatient settings, including observation units.
  - iii. **Registration and Billing Notices.** Patients will be provided various information and notices in their registration and billing communications. For example, see the Organization's Debt Collection Policy.
  - iv. **Notification to the Community.** The Organization shall take various efforts to widely publicize its Financial Assistance programs, such as distributing information to targeted community organizations or other means of alerting the community to the availability of the Organization's Financial Assistance programs.
- h. Translations and Interpreter Services.** Patient communications shall comply with the requirements of the Organization. Without limiting the foregoing, notices, formal communications and signage under this Policy shall be in English and in the additional languages required by state and federal laws. Those additional languages are Chinese, Farsi, Vietnamese, Arabic,

Czech, Russian, Armenian, Korean and Spanish. Additionally, patients may contact the Organization to be connected with interpreter services for communication and translation of Policy-related documents in other foreign languages and American Sign Language (ASL). Also, copies of these documents can be provided in large print and audio, upon request to the Patient Services Department.

- i. **Medically Necessity/Clinical Determinations.** The evaluation of the necessity for medical treatment of any patient will be based upon clinical judgment, regardless of insurance or financial status. In cases where an emergency medical condition exists, any evaluation of financial arrangements will occur only after an appropriate medical screening examination has occurred and necessary stabilizing services have been provided in accordance with all applicable state and federal laws.
- j. **Refunds.** The Organization will reimburse patients for amounts they paid in excess of the amount due pursuant to this Policy, including any interest paid, at the rate of ten percent (10%) per annum. If the amount due to the patient is less than \$5.00 (or such other amount set by the Internal Revenue Service), the Organization is not required to reimburse the patient or pay interest. The Organization shall refund the patient within 30 days.
- k. **Collections.** For additional information on collection actions, please see the Debt Collection Policy.
- l. **Reporting.** The Organization will submit this Policy to HCAI every other year on or before January 1 or within thirty (30) days of any update to this Policy. If there are no significant changes since the Policy was previously submitted, the Organization shall notify HCAI within thirty (30) days prior to the January 1 of the Organization's next biennial reporting date. Significant changes include any change that could affect patient access to eligibility for discounted payment or any other protections outlined by federal and state requirements. Each policy submission to HCAI shall include a statement of certification (see Attachment D) under penalty or perjury, which includes the following: (i) A certification that the submitter is duly authorized to submit the policies and (ii) The submitted policies are true and correct copies of the Organizations policies.

**III. Hospital Bill Complaint Program.** Patients that believe they have been wrongly denied financial assistance may file a complaint with the State of California's Hospital Bill Complaint Program. To learn more information or to file a complaint go to the HCAI website or [HospitalBillComplaintProgram.hcai.ca.gov](http://HospitalBillComplaintProgram.hcai.ca.gov).

**IV. More Help.** For patients that need help paying a bill, there are free consumer advocacy organizations that will help patients understand the billing and payment process. Patients may call the Health Consumer Alliance at 888-804-3536 or go to [healthconsumer.org](http://healthconsumer.org) for more information.

**V. APPROVAL BY BOARD OF DIRECTORS AND CONTINUING REVIEW:**

This Policy, the Debt Collection Policy, and all material changes to these policies must be approved by the Organization's Board of Directors. The Organization shall routinely review this Policy together with the Debt Collection Policy, and the status of collection efforts to ensure they are best serving patients and the community. However, administrative changes to the Attachments identified in Section VII of this Policy may be made by management without Board approval so long as the changes do not conflict with

this Policy (e.g., language clarifications, changes to reflect operational process that implement the Policy, updates to comply with changes in applicable laws, regulation, or IRS guidance, and updates to reflect the most recent Federal Poverty Guidelines).

## VI. DEFINITIONS

- a. **Amounts Generally Billed (“AGB”)** means the amounts generally billed for emergency or other medically necessary care to patients who have insurance covering such care, determined in accordance with 26 C.F.R. §1.501(r)-5(b). Additional information on how the Organization calculates AGB and annual updates to AGB percentages shall be set forth on Attachment C to this Policy and will be included in filings made available to the public on the State of California’s Department of Health Care Access and Information website at <https://syfphr.hcai.ca.gov/>.
- b. **Application** means the Organization’s Application for financial assistance.
- c. **Assets** mean only “monetary assets.” This includes assets that are readily convertible to cash, such as bank accounts and publicly traded stocks. Retirement plans, deferred compensation plans (both qualified and nonqualified under the IRS code) will not be considered. The following are excluded from Assets: the first Ten Thousand Dollars (\$10,000) of a patient’s monetary assets and Fifty Percent (50%) of the patient’s monetary assets over the first Ten Thousand Dollars (\$10,000).
- d. **Community Partners** means supportive relationships with other community agencies.
- e. **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 childcare, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.
- f. **Extraordinary Collection Actions (“ECAs”)** means collection activities that the Organization will not undertake before making reasonable efforts to determine whether a patient is eligible for financial assistance under this Policy. ECAs are specifically described in the Debt Collection Policy.
- g. **Family** means the following: (1) 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, (2) For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.
- h. **Federal Poverty Level (“FPL”)** means the measurement used to determine poverty in the United States and is published periodically by the Department of Health and Human Services (“DHHS”) on their website, <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>.
- i. **Financially Qualified Patient** means a patient who has requested financial assistance from the Organization and has completed and submitted an Application. Review of the Application shows that the patient is eligible for financial assistance and the Application is approved in accordance with this Policy or the patient has been determined by the Organization to be presumptively eligible for financial assistance under this Policy.

- j. **Financial Assistance** means arrangements under this Policy for health care services to be provided at no charge or a reduced charge to the patient. Reduced charges are generally pursuant to a payment plan or an automatic discount for Self-Pay patients.
- k. **High Medical Costs** means the annual out-of-pocket costs of a patient whose family income exceeds the Organization's thresholds for financial assistance. These costs are considered if they are either: (i) incurred by the patient at the Organization's hospital that exceed the lesser of the patient's current family income or family income in the prior twelve (12) months, or (ii) out-of-pocket medical expenses that exceed ten percent (10%) of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior twelve (12) months.
- l. **Medical Indigency** means a patient who is unable to pay for services due to unexpected high-cost care but who does not qualify for financial assistance under this Policy.
- m. **Medically Necessary** means health care services performed that is necessary and clinically appropriate to evaluate, diagnose, or treat a patient in accordance with generally accepted standards of medical practice and is not primarily for the convenience of the patient or provider.
- n. **Payment Plan** means a written agreement between the Organization and the patient, whereby the Organization has offered, and the patient has accepted, the opportunity to pay off their liability in monthly payments not exceeding 10% of the patient's family income for a month, excluding deductions for essential living expenses.

## VII. REFERENCES

State and federal laws referenced in the development of this Policy include but are not limited to:

- i. U.S. Internal Revenue Code Section 501(r)(3).
- ii. California Health & Safety Code Section 127400-127462 (Hospital Fair Pricing Policies and Emergency Physician Fair Pricing Policies).
- iii. California Assembly Bill 1020: Health Care Debt and Fair Billing, effective January 1, 2022.
- iv. California Assembly Bill 532: Fair Billing Policies, effective January 1, 2022.
- v. Office of General, Department of Health and Human Services ("OIG") guidance regarding financial assistance to uninsured and underinsured patients, and IRS regulations.
- vi. Any implementing regulations and agency guidance regarding any of the foregoing.

## VIII. LIST OF ATTACHMENTS

- A. Summary of Financial Assistance - Plain Language Summary
- B. Financial Assistance Discount
- C. Amounts Generally Billed
- D. Statement of Certification



## **SUMMARY OF FINANCIAL ASSISTANCE AND SURPRISE BILLING PROTECTIONS**

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As part of our mission, Pasadena Hospital Association, Ltd., dba Huntington Hospital and The Huntington Medical Foundation dba Huntington Health Physicians (the “Organization”) are committed to providing access to quality healthcare for the community and treating all of our patients with dignity, compassion and respect. This includes providing services without charge, or at significantly discounted prices, to eligible patients who cannot afford to pay for care as provided by our financial assistance policy (the “Policy”). We also offer our patients a variety of payment plans and options to meet their financial needs, even if they do not qualify for assistance. This document is our plain language summary (the “Summary”) of the Policy.

### **Help paying your bill**

Financial assistance will be made available to patients receiving medically necessary procedures and whose income and monetary assets (together “income”) are at or below 400% of the current year’s federal poverty level (FPL). Patients whose income ranges between 401%–600% of the FPL also qualify for discounted care. Discounts available to patients will be on a sliding scale based on family size, income level and insurance status. Financial assistance for elective or non-medically necessary procedures or for care following discharge is limited to patients who live in the Organization’s service area and have prior approval by the vice president, Finance and Chief Revenue Cycle Officer or their designee. If a patient does not qualify for entirely free services but is eligible for a discount under the Policy, the patient will not be charged more than amounts generally billed by the Organization for emergency or other medically necessary care.

### **Physicians and services**

The Policy only applies to services provided by the Organization and only includes physician services if provided by Huntington Aligned Medical Group (“HAMG”) and Huntington Foundation Medical Group (“HFMG”). It excludes the Organization’s Randall Breast Center locations, Huntington Ambulatory Surgery Center, LLC and Huntington Outpatient Imaging Centers, LLC.

### **How to apply**

Patients seeking free or discounted care under the Policy will need to complete a financial assistance application (the “Application”) and submit any required documentation. The Application and documentation will go through a review process by the Organization.

Free copies of this Summary, the Policy or the Application are available in English, Chinese, Farsi, Armenian, Vietnamese, Arabic, Czech, Russian, Korean and Spanish. To request copies or to get additional information, including questions on the financial assistance process, you may:

- Ask representatives at the registration or admissions desks.
- Call Patient Services at 323-866-8600.

- Visit the Organization’s website at [huntingtonhealth.org/patients/pay-your-bill/help-paying-your-bill/](http://huntingtonhealth.org/patients/pay-your-bill/help-paying-your-bill/)

If you have a disability and need an accessible alternative format for the above materials or if you speak another language than those listed, please contact Patient Services and they can offer you an alternative format or connect you with our Interpreter Services department for further assistance.

### **Arrangements for self-pay**

Patients who do not qualify for free or discounted care under the Policy may find other programs of the Organization helpful. Patients who lack insurance may receive a substantial discount, similar to the discounts we provide to managed-care insurance plans for eligible services.

### **Regulatory notice for collections**

We do refer some delinquent accounts to third-party collection agencies. These agencies must follow all California and federal laws as well as comply with the Organization’s policies and procedures. For more information about debt collection activities, you may contact the Federal Trade Commission by phone at 877-FTC-HELP (877-382-4357). In the event your account is referred to a collection agency and you experience problems, contact our Patient Services for support at 323-866-8600.

### **Protections for surprise medical bills**

All patients are afforded protections against surprise medical bills. Please see the “Notice to Patients – Your Rights and Protections Against Surprise Medical Bills” on our website [huntingtonhealth.org/patients/cost-of-care/no-surprises-act-nsa-surprise-medical-bills-no-surprise-billing-policies](http://huntingtonhealth.org/patients/cost-of-care/no-surprises-act-nsa-surprise-medical-bills-no-surprise-billing-policies).

### **Hospital Bill Complaint Program**

If you believe you were wrongly denied financial assistance, you may file a complaint with the State of California’s Hospital Bill Complaint Program. Go to [HospitalBillComplaintProgram.hcai.ca.gov](http://HospitalBillComplaintProgram.hcai.ca.gov) for more information and to file a complaint.

### **More help**

Help paying your bill – There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to [healthconsumer.org](http://healthconsumer.org) for more information.

### **Additional resources and information:**

- Patients may be eligible for government assistance programs, such as Medi-Cal or subsidized coverage through Covered California. The Patient Financial Advocate (“PFA”) office has onsite staff to answer patient questions and provide assistance with applying for these programs. The PFA office can be contacted at 310-423-5071.
- For questions regarding commercial health insurance, call 1-800-CEDARS-1 (1-800-233-2771).
- For information on the Organization’s pricing and tool for shoppable services, visit [huntingtonhealth.org/patients/cost-of-care](http://huntingtonhealth.org/patients/cost-of-care)

**Attachment B - Financial Assistance Discount**

**Financial Assistance Discount  
Federal Poverty Guidelines**

<b>Uninsured Discount</b>	<u>100%</u>	<u>95%</u>	<u>90%</u>	<u>85%</u>	<u>85%</u>
<b>Underinsured Discount</b>	<u>100%</u>	<u>90%</u>	<u>80%</u>	<u>70%</u>	<u>60%</u>

<b>Size of Family Unit</b>	<b>FPL Annual Salary</b>					
1	\$14,580	\$58,320	\$65,610	\$72,900	\$80,190	\$87,480
2	\$19,720	\$78,880	\$88,740	\$98,600	\$108,460	\$118,320
3	\$24,860	\$99,440	\$111,870	\$124,300	\$136,730	\$149,160
4	\$30,000	\$120,000	\$135,000	\$150,000	\$165,000	\$180,000
5	\$35,140	\$140,560	\$158,130	\$175,700	\$193,270	\$210,840
6	\$40,280	\$161,120	\$181,260	\$201,400	\$221,540	\$241,680
7	\$45,420	\$181,680	\$204,390	\$227,100	\$249,810	\$272,520
8	\$50,560	\$202,240	\$227,520	\$252,800	\$278,080	\$303,360
For each additional person, add	\$5,140					
		400%	450%	500%	550%	600%

Note: Schedule Last Revised 1/16/2023

**Attachment C - Amounts Generally Billed**

Amounts Generally Billed (“AGB”) means the amounts generally billed for emergency or other medically necessary care to Patients who have insurance covering such care, determined in accordance with 26 C.F.R. §1.501(r)-5(b).

The Organization will use the Look-Back Method for determining the maximum amount that would be billed to an eligible inpatient using the average Medicare and commercial inpatient reimbursement rate. To further benefit an eligible inpatient, the Organization will use the lower of the AGB or the Medicare MS-DRG reimbursement amount for this episode of care in determining an eligible patient’s liability.

The Organization will use the Look-Back Method in determining the maximum amount that would be billed to an eligible outpatient using the average Medicare and Commercial outpatient reimbursement rate.

The Organization will use the Look-Back Method in determining the maximum amount that would be billed to an eligible emergency room patient using the average Medicare and Commercial emergency room reimbursement rate.

Inpatient, outpatient and emergency room reimbursement rates are calculated at least annually using the most recently closed Medicare and commercial accounts from the past 12 months.

**Effective 11/07/2022**

<b>The Organization</b>	<b>Uninsured Self-Pay Discounts</b>	<b>AGB Reimbursement %</b>
Emergency Room	82%	18%
Inpatient	82%	18%
Outpatient	81%	19%

**Effective 07/01/2023**

<b>The Organization</b>	<b>Uninsured Self-Pay Discounts</b>	<b>AGB Reimbursement %</b>
Emergency Room	82%	18%
Inpatient	82%	18%
Outpatient	82%	18%



**Attachment D - Statement of Certification**



**Statement of Certification**  
**Financial Assistance Policy**

This Policy will be submitted to the Department of Health Care Access and Information (HCAI). Additionally, it will be made available on the Organization’s website.

The Organization attests under penalty or perjury to the following:

1. The individual submitting the policy is duly authorized to submit policies on behalf of the Organization.
2. This submitted policy is a true and correct copy of the Policy for which this certification is included.

DocuSigned by:  
*Lisa Maqueira*  
50A5E2AB075D487  
\_\_\_\_\_  
Lisa Maqueira  
Vice President, Finance and Chief Revenue Cycle Officer

12/8/2023 | 12:59 PM PST  
\_\_\_\_\_  
Date