SAN BERNARDINO MOUNTAINS COMMUNITY HOSPITAL DISTRICT

DEPARTMENT: PATIENT FINANCIAL SERVICES	POLICY#
TITLE: CHARITY CARE & DISCOUNT PAYMENT (PARTIAL	ORIGINATION DATE: 1/90
REVISION DATES: 01/01/2015	PAGE 1 of 6

San Bernardino Mountains Community Hospital District (the Hospital) offers charity care (free care) and discount payments (partial charity care) to financially qualified patients. Financially qualified patients must meet the eligibility criteria as defined below. The eligibility process which involves obtaining necessary information from the patient must be followed.

Hospital services eligible under the charity care program include inpatient & outpatient services which are medically necessary.

This policy applies to Hospital charges only. It does not apply to fees billed by Physicians and other allied professionals.

However, treatment provided by an emergency physician in the emergency department of the Hospital will be billed by the physician who rendered professional services. EMERGENCY PHYSICIAN SERVICES TO QUALIFYING PATIENTS ARE SUBJECT TO DISCOUNT IN ACCORDANCE WITH STATE LAW. Please contact the emergency physician representative directly at the telephone number listed on your doctor's bill to obtain information regarding such discounts.

Definitions

Self-pay/uninsured patients: A patient who does not have third party coverage from a health insurer, health care service plan, Medicare or Medi-Cal and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the Hospital.

Patient's family: For patients 18 years of age or older, the family includes the patient's spouse, registered domestic partner, and dependent children under 21 years of age, whether living at home or not. For patients under 18 years of age, the family includes the patient's parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

Federal Poverty Level (FPL): The poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services.

Qualified Payment Plan: Payment plans established by patients who have qualified for Discount Payment through the Charity Care/Discount Payment Policy are classified as a Qualified Payment Plan. A Qualified Payment Plan shall have no interest charges applied to any or all balances due from the patient/guarantor. In the event that the Hospital and the patient/guarantor cannot reach agreement on terms for a qualified payment plan, the hospital shall use the formula described in Health & Safety Code Section 127400 (i), in order to establish terms for a "Reasonable payment plan," as defined in statute.

Eligibility (Charity Care & Partial Charity Care)

Uninsured Patients:

- If an uninsured patient's family income is 200% or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, the patient qualifies for full charity care.

- If an uninsured patient's family income is between 201% and 300% of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, the following will apply:

    - Patient will be required to pay a percentage of the gross amount that the Medicare Program would have paid for the service if the patient had been a Medicare beneficiary. The gross amount Medicare would have paid shall be calculated using the interim rates that apply to the dates of service. The actual percentage paid by any individual patient shall be based on the sliding scale shown in Table 1 below:

TABLE 1
Sliding Scale Payment Schedule

Family Percentage of FPL	Percentage of Medicare Amount Payable
201 – 225%	**20%**
226 – 250%	**40%**
251 – 275%	**60%**
276 – 300%	**80%**

Insured Patients:

- If an insured patient's family income is between 0% and 300% of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, the following will apply:

    - If the services are covered by a third party payer and the patient owes a co-payment, deductible, or any other amount, but is unable to pay the amount due and seeks financial assistance, the patient's payment obligation will be based on a sliding scale for patient portion due. The actual percentage paid by any individual patient shall be based on the sliding scale shown in Table 2 below:

TABLE 2

Insured Patient Sliding Scale Payment Schedule

Family Percentage of FPL	Percentage of Amount Due
Less than 200%	40%
201 – 250%	60%
251 – 300%	80%

Special Circumstances – Other Eligibility Criteria:

- Any patient whose income exceeds 300% of the FPL and experiences a catastrophic medical event may be deemed eligible for financial assistance. However, consideration as a catastrophic medical event may be made on a case-by-case basis and is determined at the sole discretion of hospital management. The determination of a catastrophic medical event shall be based upon the amount of the patient liability at billed charges, and consideration of the individual's income and assets as reported at the time of occurrence.

- The following circumstances are deemed to qualify with our charity program:

    - Homeless patients
    - Deceased patients who do not have any third party coverage, an identifiable estate or for whom no probate hearing is to occur
    - Patients who have been declared bankrupt by a federal bankruptcy court order within the past twelve (12)months
    - Patients seen in the emergency department for whom the Hospital is unable to issue a

billing statement

- Patients that are eligible for government sponsored low-income assistance programs when such programs deny payment or make only partial payment. For example, denied days or denied charges.
- Accounts sent to a collection agency, when such agency determines the patient is unable to pay the account.

Eligibility Process

Uninsured patients will be informed of charity care and other coverage programs prior to completion of service and they will receive applications for charity and/or appropriate government programs. See Attachment A for a copy of the Hospital's Charity Care application.

The Hospital's Financial Counselor will assist patients to complete charity care and other program applications.

Patients must provide proof of income documents with the charity care application. The following documents are accepted as proof of income:

- I*f you filed a federal income tax return you must submit a copy of*
  - Signed federal income tax return (Form 1040) from the most recent year. You must include all schedules and attachments as submitted to the Internal Revenue Service;
- *If you did not file a federal income tax return, you must submit the following:*
  - Two (2) most recent paycheck stubs: **and**
  - A letter explaining why you do not file a federal income tax return
- *lf you have no income, or proof of income documents, you must provide a letter explaining how you support yourself/family. The Hospital will take this information into consideration.*

Timing of eligibility determination:

Patients should submit all requested information within 14 days of receiving Charity Care application.

Eligibility for charity care or discount payment (partial charity care) will be determined when the Hospital is in receipt of income documentation.

Once an eligibility determination has been reached, the patient will be notified in writing if they have been approved for full or partial charity care. Patients will also be notified in writing if their application was denied.

The Hospital may apply approved charity care (full or partial) to multiple accounts for the same patient at its sole and exclusive discretion.

Qualified Payment Plans:

When a determination of discount has been made by the Hospital, the patient shall have the option to pay any or all outstanding amount due in one lump sum payment or through a scheduled term Qualified Payment Plan.

The Hospital will discuss payment plan options with each patient that requests to make arrangements for term payments. Individual payment plans will be arranged based upon the patient's ability to effectively meet the payment terms. As a general guideline, payment plans will be structured to last no longer than 12 months.

The Hospital shall negotiate in good faith with the patient; however there is no obligation to accept the payment terms offered by the patient. In the event that the Hospital and an individual patient or guarantor cannot reach an agreement to establish a Qualified Payment Plan, the hospital will use the "Reasonable payment plan" formula as defined in Health & Safety Code Section 127400 (i) as the basis for a payment plan. A "Reasonable payment plan" means monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses. In order to apply the "Reasonable payment plan" formula, the Hospital shall collect patient family information on income and "Essential living expenses" in accordance with the statute. The Hospital shall use a standardized form to collect such information. Each patient or guarantor seeking to establish a payment plan by applying the "Reasonable payment plan" formula shall submit the family income and expense information as requested, unless the information request is waived by representatives of the Hospital.

No interest will be charged to Qualified Payment Plan accounts for the duration of any payment plan arranged under the provisions of the Charity Care/Discount Payment Policy.

Once a Qualified Payment Plan has been approved by the Hospital, any failure to pay all consecutive payments due during a 90-day period will constitute a payment plan default. It is the patient or guarantor's responsibility to contact the Hospital Patient Business Office if circumstances change and payment plan terms cannot be met. However, in the event of a payment plan default, the Hospital will make a reasonable attempt to contact the patient or their family representative by telephone and also give notice of the default in writing. The patient shall have an opportunity to renegotiate the extended Qualified Payment Plan and may do so by contacting a Patient Business Office representative within Fourteen (14) Days from the date of the written notice of extended payment plan default. If the patient fails to request renegotiation of the

extended payment plan within Fourteen (14) Days, the payment plan will be deemed inoperative and the account will become subject to collection.

Dispute Resolution Process:

In the event that a dispute arises regarding Financial Assistance Program qualification, the patient may file a written appeal for reconsideration with the Hospital. The written appeal should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any or all additional relevant documentation to support the patient's claim should be attached to the written appeal.

Disputes concerning eligibility will be reviewed by the Hospital's Chief Financial Officer (CFO). The CFO's decision is final and there are no further appeals.

Notices

Charity Care notices are posted in English and Spanish in the following locations:

- All Registration areas
- Business Office

Statement of "Good Faith:"

The Hospital provided services in good faith in order to meet the needs of the patient. It is a reasonable expectation that the Patient will also act in good faith and will cooperate with the Hospital by providing requested information.

In the event that we determine that the Patient has provided false or misleading information, Hospital will pursue collection for the entire balance of the account and seek any other remedy available under law.

Statement of Confidentiality:

Information obtained through the Charity Care process is considered confidential and will be maintained as such by all Hospital personnel.

DEPARTMENT: **PATIENT FINANCIAL SERVICES**	POLICY#
TITLE: **CREDIT AND COLLECTION POLICY**	ORIGINATION DATE: 07/10
REVISION DATES: 3/11, 1/1/2015	Page 7 of 13
REVIEW DATES:	
ATTACHMENTS REVIEWED:	

PURPOSE:

San Bernardino Mountains Community Hospital District (SBMCHD) provides high quality care to patients when they are in need of hospital services. All patients or their guarantor have a financial responsibility related to services received at SBMCHD and must make arrangements for payment to SBMCHD either before or after services are rendered. Such arrangements may include payment by an insurance plan, including coverage programs offered through the federal and state government. Payment arrangements may also be made directly with the patient, subject to the payment terms and conditions of SBMCHD.

Emergency patients will always receive all medically necessary care within the scope resources available at SBMCHD, to assure that their medical condition is stabilized prior to consideration of any financial arrangements.

The Credit and Collection Policy establishes the guidelines, policies and procedures for use by hospital personnel in evaluating and determining patient payment arrangements. This policy is intended to establish fair and effective means for collection of patient accounts owed to the hospital. In addition, other SBMCHD policies such as the Charity Care and Discount Payment Policy which contains provisions for full charity care and discount partial charity care will be considered by SBMCHD personnel when establishing payment arrangements for each specific patient or their guarantor.

SCOPE:

The Credit and Collection Policy will apply to all patients who receive services at SBMCHD. This policy defines the requirements and processes used by the hospital Patient Financial Services department when making payment arrangements with individual patients or their account guarantors. The Credit and Collection Policy also specifies the standards and practices used for the collection of debts arising from the provision of services to patients at SBMCHD. The Credit and Collection Policy acknowledges that some patients may have special payment arrangements as defined by an insurance contract to which SBMCHD is a party, or in accordance with hospital conditions of participation in state and federal programs. SBMCHD endeavors to treat every patient or their guarantor with fair consideration and respect when making payment arrangements.

All requests for payment arrangements from patients, patient families, patient financial guarantors, physicians, hospital staff or others shall be addressed in accordance with this policy.

POLICY:

All patients who receive care at SBMCHD must make arrangements for payment of any or all amounts owed for hospital services rendered in good faith by SBMCHD. SBMCHD reserves the right and retains sole authority for establishing the terms and conditions of payment by individual patients and/or their guarantor, subject to requirements established under state and federal law or regulation.

GENERAL PRACTICES:

1. SBMCHD and the patient share responsibility for timely and accurate resolution of all patient accounts. Patient cooperation and communication is essential to this process. SBMCHD will make reasonable, cost-effective efforts to assist patients with fulfillment of their financial responsibility.

2. Hospital care at SBMCHD is available to all those who may be in need of necessary services. To facilitate financial arrangements for persons who may be of low or moderate income, both those who are uninsured or underinsured, SBMCHD provides the following special assistance to patients as part of the routine billing process:

   a. For uninsured patients, a written statement of full itemized charges for services rendered by the hospital is provided to the patient.

   b. Upon request, patients who have third party insurance will be provided a revenue code summary statement which identifies the charges related to hospital services. Insured patients will receive a balance due from patient statement once the hospital has received payment from the insurance payer. Upon patient request, a complete itemized statement of charges will be provided;

   c. A written request that the patient inform SBMCHD if the patient has any health insurance coverage, Medicare, Medi-Cal, Covered California, or other form of insurance coverage;

   d. A written statement informing the patient or guarantor that they may be eligible for Medicare, Medi-Cal, Covered California, California Children's Services Program, or the SBMCHD Charity Care and Discount Payment Program;

   e. A written statement indicating how the patient may obtain an application for the Medi-Cal

Program, Covered California, or other appropriate government coverage program;

f. If a patient is uninsured, an application to the Medi-Cal Program, Covered California, or other appropriate government assistance program will be provided prior to discharge from the hospital;

g. A SBMCHD representative is available at no cost to the patient to assist with application to relevant government assistance programs;

h. A written statement regarding eligibility criteria and qualification procedures for full charity care and/or discount partial charity care under the SBMCHD Charity Care and Discount Payment Program. This statement shall include the title and telephone number of hospital personnel who can assist the patient or guarantor with information about and an application for the SBMCHD Charity Care Program.

i. Uninsured patients will also be provided contact information for local consumer legal assistance programs which may assist the uninsured patient with obtaining coverage.

3. The SBMCHD Patient Financial Services department is primarily responsible for the timely and accurate collection of all patient accounts. Patient Financial Services personnel work cooperatively with other hospital departments, members of the Medical Staff, patients, insurance companies, collection agencies and others to assure that timely and accurate processing of patient accounts can occur.

4. Accurate information provides the basis for SBMCHD to correctly bill patients or their insurer. Patient billing information should be obtained in advance of hospital services whenever possible so that verification, prior authorization or other approvals may be completed prior to the provision of services. When information cannot be obtained prior to the time of service, hospital personnel will work with each patient or their guarantor to assure that all necessary billing information is received by SBMCHD prior to the completion of services.

PROCEDURES:

A. Each patient account will be assigned to an appropriate Patient Financial Services representative based upon the type of payer and current individual staff workloads. The PFS Manager will periodically review staff workloads and may change or adjust the process or specific assignment of patient accounts to assure timely, accurate and cost-effective collection of such accounts.

B. Account details will be reviewed to assure accuracy and completeness of information necessary for the account to be billed.
C. If the account is payable by the patient's insurer, the initial bill will be forwarded directly to the designated insurer. SBMCHD Patient Financial Services personnel will work with the patient's insurer to obtain any or all amounts owed on the account by the insurer. This will include calculation of contracted rates or other special arrangements that may apply. Once payment by the insurer has been determined by SBMCHD, any residual patient liability balance, for example a patient co-payment or deductible amount, will be billed directly to the patient. Any or all patient balances are due and payable within 30 days from the date of this first patient billing.
D. If the account is payable only by the patient, it will be classified as a private pay account. Private pay accounts may potentially qualify for a prompt payment discount, government coverage programs, or financial aid under the SBMCHD Charity Care and Discount Payment Policy. Patients with accounts in private pay status should contact a Patient Financial Services representative to obtain assistance with qualifying for one or more of these options.
E. In the event that a patient or patient's guarantor has made a deposit payment, or other partial payment for services and subsequently is determined to qualify for full charity care or discount partial charity care, all amounts paid which exceed the payment obligation, if any, as determined through the Charity Care and Discount Payment Program process, shall be refunded to the patient with interest. Any overpayment due to the patient under this obligation may not be applied to other open balance accounts or debt owed to the hospital by the patient or family representative, without written authorization from the patient or family representative. Any or all amounts owed shall be reimbursed to the patient or family representative within a reasonable time period. Interest shall begin to accrue on the first day that payment by the patient is received by the hospital. Interest amounts shall be accrued at Ten Percent (10%) per annum. In the event that the amount of interest owed to the patient as part of a refund is less than Five Dollars ($5.00), no interest amount will be paid to the patient. However, in cases where the interest amount due is less than Five Dollars ($5.00), SBMCHD shall issue a credit to the patient for the amount due for at least 60 days from the date the amount is due.
F. The Hospital offers patients/responsible parties an extended payment plan option when they are not able to settle the account in one lump sum payment. Extended payment plans are established on a case-by-case basis through consideration of the total amount owed by the patient/responsible party to the Hospital and the patient’s/responsible party’s financial circumstances. Extended payment plans generally require a minimum monthly payment of an amount such that the term of the payment plan shall not exceed twelve (12) months. Once an extended payment plan has been agreed to by the patient/guarantor, failure to make all consecutive payments due during any 60-day period will constitute a payment plan default. Written notice of extended payment plan default will be provided to the patient/guarantor. It is the patient/responsible party’s responsibility to contact the Hospital Patient Business Office if

circumstances change and payment plan terms cannot be met. Failure to do so may result in the account being forwarded to collection status.

G. Patients/responsible parties who have qualified for the Hospital discounted partial financial assistance are eligible for a Qualified Payment Plan as described in the Mountains Community Hospital Charity Care/Discount Payment Policy. Qualified payment plans involve negotiation between the hospital and patient/responsible party and may result in a payment plan term which exceeds twelve (12) months. Qualified payment plans may be arranged by contacting a hospital Patient Business Office representative. Qualified payment plans are free of any interest charges. Once a qualified payment plan has been approved by the Hospital, any failure to pay all consecutive payments due during any 90-day period will constitute a payment plan default. It is the patient/responsible party's responsibility to contact the Hospital Patient Business Office if circumstances change and payment plan terms cannot be met. However, in the event of a payment plan default, the Hospital will make a reasonable attempt to contact the patient/responsible party by telephone and also give notice of the default in writing. The patient/responsible party shall have an opportunity to renegotiate the extended payment plan and may do so by contacting a Patient Business Office representative within Fourteen (14) Days from the date of the written notice of extended payment plan default. If the patient/responsible party fails to request renegotiation of the extended payment plan within Fourteen (14) Days, the payment plan will be deemed inoperative and the account may become subject to collection.

H. Patient account balances in private pay status will be considered past due after 30 days from the date of initial billing. Accounts may be advanced to collection status according to the following schedule:

   a. Any or all private pay account balances where it is determined by SBMCHD that the patient or guarantor provided fraudulent, misleading or purposely inaccurate demographic or billing information may be considered as advanced for collection immediately upon such a determination by SBMCHD. Any such account will be reviewed and approved for advancement by the PFS Manager or her/his designee;

   b. Any or all private pay account balances where no payment has been received, and the patient has not communicated with SBMCHD within 60 days of initial billing and a minimum of one bill showing itemized details and two cycle statements have been sent to the patient or guarantor. Any such account will be reviewed and approved for advancement by the PFS Manager or her/his designee;

   c. Any or all other patient accounts, including those where there has been no payment within the past 60 days, may be forwarded to collection status when:

      1. Notice is provided to the patient or guarantor that payments have not been made in a timely manner and the account will be subject to collection 30 days from the notice date;

2. The patient or guarantor refuses to communicate or cooperate with SBMCHD Patient Financial Services representatives; and
3. The PFS Manager or her/his management designee has reviewed the accow1t prior to forwarding it to collection status.

I. Patient accounts will not be forwarded to collection status when the patient or guarantor makes reasonable efforts to communicate with SBMCHD Patient Financial Services representatives and makes good faith efforts to resolve the outstanding account. The SBMCHD PFS Manager or her/his designee will determine if the patient or guarantor are continuing to make good faith efforts to resolve the patient account and may use indicators such as: application for Medi-Cal, Covered California, or other government programs; application for the SBMCHD Charity Care and Discount Payment Program; regular partial payments of a reasonable amount; negotiation of a payment plan with SBMCHD and other such indicators that demonstrate the patient's effort to fulfill their payment obligation.

J. After 30 days or anytime when an account otherwise becomes past due and subject to internal or external collection, SBMCHD will provide every patient with written notice in the following form:

a. "State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at www.ftc.gov."

b. Non-profit credit counseling services may be available in the area. Please contact the SBMCHD Patient Financial Services if you need more information or assistance in contacting a credit counseling service.

K. For all patient accounts where there is no 3rd party insurer *and/or* whenever a patient provides information that he or she may have high medical costs, the Patient Financial Services representative will assure that the patient has been provided all elements of information as listed above in number 2, parts (a) through (i). This will be accomplished by sending a written billing supplement with the first patient bill. The Patient Financial Services representative will document that the billing supplement was sent by placing an affirmative statement in the "notes" section of the patient's account.

L. For all patient accounts where there is no 3rd party insurer *and/or* whenever a patient provides information that he or she may have high medical costs, SBMCHD will not report adverse information to a credit reporting agency or commence any civil action prior to 150 days after initial billing of the account. Furthermore, SBMCHD will not send an unpaid bill for such patients to an external collection agency unless the collection agency has agreed to comply with this requirement.

M. If a patient or guarantor has filed an appeal for coverage of services in accordance with Health & Safety Code Section 127426, SBMCHD will extend the 150 day limit on reporting of adverse information to a credit reporting agency and/or will not commence any civil action until a final determination of the pending appeal has been made.

N. SBMCHD will only utilize external collection agencies with which it has established written contractual agreements. Every collection agency performing services on behalf of SBMCHD must agree to comply with the terms and conditions of such contracts as specified by SBMCHD. All collection agencies contracted to provide services for or on behalf of SBMCHD shall agree to comply with the standards and practices defined in the collection agency agreement; including this Credit and Collection Policy, the SBMCHD Charity Care and Discount Payment Policy and all legal requirements including those specified in the California Health & Safety Code Section.

O. SBMCHD and/or its external collection agencies will not use wage garnishments or liens on a primary residence without an order of the court. Any or all legal action to collect an outstanding patient account by SBMCHD and/or its collection agencies must be authorized and approved in advance, in writing by the SBMCHD PFS Manager. Any such legal action must confound to the requirements of the California Health & Safety Code Section.

P. SBMCHD, its collection agencies, or any assignee may use any or all legal means to pursue reimbursement, debt collection and any enforcement remedy from third-party liability settlements, tortfeasors, or other legally responsible patties. Such actions shall be conducted only with the prior written approval of the SBMCHD PFS Manager.