UC San Diego Health System
UC San Diego Health System Policy and Procedures
MCP 750.1, Patient Financial Policy

Effective/July 1, 2012

ABSTRACT:

UC San Diego Health System ("UCSDHS") provides emergency, outpatient, and inpatient, diagnostic and therapeutic services across multiple locations. This Patient Financial Policy serves to define criteria applied to assess a patient's unique financial situation as it relates to healthcare services provided by UCSDHS, explain roles and responsibilities, and provide basic guidance for key patient financial activities performed by those persons and parties involved in the financial matters related to clinical services rendered by UCSDHS, which includes, but is not limited to, UCSDHS providers and staff, patients, third-party payors, amongst others. Such a policy is necessary to minimize confusion for all parties involved in these often complex patient financial matters which helps patients directly by reducing uncertainty of their financial responsibilities while also helping to keep UCSDHS financially viable so that we can to continue to carry out our mission of delivering excellent patient care, serving as a teaching facility, and conducting clinical research.

Key Components of UCSDHS's Patient Financial Policy include:

1. Definition of "Financial Clearance" at UCSDHS, including the criteria for financial clearance that adheres to applicable Federal and State regulations, the steps taken and who is responsible for determining whether or not the criteria has been met.

2. Conditions when Financial Clearance can be performed prior to services being provided versus when Financial Clearance would not be performed prior rendered services.

3. What happens if a patient is not Financially Cleared, when patients will be allowed to receive services at UCSDHS versus when services will be rescheduled or deferred and the role of the Physician in this decision-making process.

4. Definition of "Charity Care", including qualifications and differentiation between "free care" (Full Charity) and "discounted care" (Partial Charity or Self Pay Discounts/Cash Packages)

UCSDHS is committed to providing emergency services to all individuals based solely on the individual's medical need in accordance with the Emergency Medical Treatment and Labor Act (EMTLA) legislation. Additionally, if non-emergent care is deemed urgent by the patient's physician, the physician can request, on behalf of the patient, review of the case by the Dean of Clinical Affairs (or designee) who will review the clinical details and make a determination as to

whether care will or will not be provided when the patient has not been financially cleared – this is defined as a "Clinical Override". "Financial Clearance" is the term used to describe the instance when a patient has satisfied the applicable Financial Policy requirements as outlined herein.

1. **Definition of Financial Clearance:**

   "Financial Clearance" is defined as - the confirmation of insurance eligibility, confirmation of benefit coverage for the services rendered or to be rendered, authorization obtained (if applicable), and communication *attempts* by UCSDHS staff to inform patients of their benefit coverage and expected financial liability. While the definition of "Financial Clearance" is standard, the steps necessary for a patient to be financially cleared for non-emergent care at UCSDHS Medical can vary depending on variables such as:

- Presence or Absence of 3rd Party Coverage. The presence of third party coverage will also involve confirmation of eligibility with the identified insurance for the expected treatment timeframe

- Benefits (when 3rd Party Coverage is identified) for services that are pre-scheduled. This is dependent on information given by the insurance provider and if the service is *pre-scheduled* at least 48 hours in advanced.

- Authorization: Once Eligibility and Benefits have been identified, authorization, either pre-service, during an admission or retro authorization, will be attempted to be secured by the appropriate UCSDHS staff that has been designated to do this function. While this function is not centralized, it is the expectation that securing of the authorization is standardized across UCSDHS.

- Qualification for Charity or other Funding Sources

- Ability to Pay estimated charges if none of the above coverage sources are applicable

- Type of non-emergent services the patient is seeking

- Date when service(s) are to be rendered

1. Roles & Responsibilities for Completing the Financial Clearance Process and Satisfying the Criteria

   - UCSDHS:

     - Physician: A physician must order (for pre-service clearance) or order *and* to perform an non-scheduled service that must be financially cleared.

- Ancillary Physician staff, such as hospital assistants, medical assistants, authorization specialist. These staff are delegated the duties of obtaining authorization for a prescheduled service and for scheduling the service.

- Patient Access Staff: typically initiate the financial clearance process to determine whether the patient currently meets the criteria for financial clearance or if additional steps are required to financially clear the patient for the given service(s). This is done prior to and at the point of service for all scheduled patients and done at the time of service for all non-scheduled patients, such as Emergency room visits, Labor and delivery and transferred patients. Patient Access does not schedule patients and in only limited capacity does it obtain an authorization or do registration.

UCSDHS will make every attempt to complete the financial clearance process in advance of the service date and time whenever possible. UCSDHS does not guarantee that the financial clearance process with be completed prior to all services rendered. For unscheduled services, financial clearance will begin as soon as the service is rendered and may continue until all elements are completed.

The ability to complete the financial clearance process (which may result in the patient being financially cleared or not prior to service) depends in part on the physician (or designee) and the patient working with the Financial Clearance staff to provide necessary information timely. This process may change over the course of a patients care and may need to be repeated throughout a course of therapy.

UCSDHS will attempt to contact the patient prior to the scheduled services to update information from the patient and to inform the patient of the benefit coverage, authorization, and patient liability. To ensure privacy protection under the HIPAA law, UCSDHS staff can only speak to the patient or the patient's guarantor. Telephone messages regarding financial clearance cannot be left if the patient or patient's guarantor cannot be reached. UCSDHS is *not required* to contact the patient prior to scheduled services regarding the patient's financial responsibility.

It is the expectation of the independent 3rd Party payors and UCSDHS that the patient and or the financial guarantor understand the patient's insurance policy. This includes, understanding the patients eligibility under the plan's coverage, the patient's financial liability within the plans coverage, and the services that are considered a covered benefit.

Should patients not have coverage or indicate they are unable to pay out of pocket for services, Financial Counselors will work with patients and UCSDHS Clinical and Administrative staff to

financially assess patients as timely as possible. To prevent possible deferral of non-emergent care, cooperation from patients and/or their designee(s) will be necessary. The minimum information Financial Counselors will need to gather depends on the individual patient, but could include:

- 3rd Party Coverage Information (Eligibility, Benefits, Authorization/Referral, Notification)
- Financial Documentation (Financial Screening as detailed in Section 1D)
- Clinical Information from Referring and/or Attending Physician (Clinical Screening as detailed in Section 1E.
- Based on the information gathered, the Financial Counselors will work with the patient and/or their designee(s) to:

    1. Submit applications to Governmental or other Public Assistance Programs (including referral to alternative healthcare providers if appropriate). This includes: County Medical Services (CMS or related program's), Medic-aid/Medi-cal and/or PCIP.

    2. Provide a Letter of Agreement (LOA) which indicates the patient's financial responsibility to pay for services (an estimate of charges and repayment schedule).

    3. Obtain necessary approvals for the patient to receive care funded in part or in full by UCSDHS as Charity

Patients with non-emergent care needs will not be treated unless they are financially cleared to assure the Health System and Medical Group are able to mitigate financial risk and improving the ability to execute Clinical, Educational, Community elements of UCSDHS Mission.

The Financial Policy complies with the following legislation and policies:

POLICIES:

UCSDHS MCP 301.4 "Patient Admission and Discharge"
UCSDHS MCP 301.7 "Transfer and Compliance with EMTALA"
University of California Charity Determination Criteria is based on the most current Federal Poverty Level (FPL) guidelines maintained on the Federal Register by the United States Department of Health and Human Services

I. DEFINITIONS

A. **Financial Clearance:** There are 4 major types of Financial Clearance

1. Patient is covered by 3rd party source. UCSD has determined the patient has eligibility, benefits, and, if applicable, prior authorization to have the service rendered at UCSDHS. This may be done pre-service, at the point of service, or after an unscheduled service has been rendered.

2. Able and willing to pay estimated Health System charges per Letter of Agreement (LOA). The LOA will include all ordered services, including Medical Group Professional Fees, Anesthesia Professional fees, and any other known professional fees that may be applicable. The LOA is an estimate based on information provided by the requesting physician (or acting representative) prior to the service being rendered. If the actual service rendered deviates from the ordered service, the estimate of charges on the LOA will change.

3. Approved for "Charity" (financial & clinical justification) if the patient is not financially cleared. Patients may be approved for charity prior to the service being rendered or during an inpatient admission for an unscheduled admission. (Refer Section 3 for Charity Care Policy for details).

4. Clinical Override: (For non-EMTALA bound patients) A patient is not financially cleared, but the treating physician determines that the services requested is medically required and cannot be deferred. Services rendered are done so on a clinical urgent basis, but does not release the patient of his or her financially liability. The collection of the patient's financial liability will not be required at the time of service, but will be invoiced to the patient after the service is rendered.

Examples of "Financial Clearance" could include (but are not limited to):

- Patient has verified 3rd party coverage and has been authorized for the defined non-emergent services and has paid their co-pay/deductible/ co-insurance prior to receiving care

- Patient has the ability to pay out of pocket for the estimated charges at a 45% discount, has signed a letter of agreement confirming their responsibility to pay, and makes such payment per the arrangement (no less than 50% of the arranged amount in advance of service being provided) .

- Patient meets criteria necessary to qualify for Government sponsored funding and is cooperative throughout the application process and an application for sponsorship has been submitted prior to care being rendered .

- Patient meets Charity Care criteria and UCSDHS has approved Full or Partial Charity in advance of service being rendered.

B. **Emergent Medical Condition**: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the patient's health in jeopardy;

2. Serious impairment of bodily functions*;*

3. Serious dysfunction of any bodily organ or part.

C. **Emergency Medical Services and Care**: Medical screening, examination, and evaluation by a qualified medical professional, to determine if an emergency medical condition or active labor exists and, if it does: the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

D. **Financial Screening**: Financial screening shall include the following activities:

1. Verification of a patient's benefits and eligibility for coverage by an insurance or public program;

2. Identification of and compliance with authorization requirements imposed by payors;

3. Identification and collection of the estimated patient liability for the services to be rendered and the establishment of payment arrangements;

4. Review and collection of outstanding accounts, which are due to UCSDHS for previously rendered services;

5. Referral to appropriate health care or medical assistance resources to secure coverage or obtain services; and

6. Determination of the patient's ability to pay for services not covered by a third party payor.

7. UCSDHS will make an *attempt* to contact patient prior to the scheduled service regarding eligibility, benefits, authorization, and an estimate of patient liability. UCSDHS is not *required* to make contact with the patient prior to service.

E. **Clinical Screening:** Clinical Screening is to be done when a request for charity has been initiated.
1. Clinical Screening may be done by the Lead Case Manager or designee if the request for charity is for post-acute care discharge needs. This review will determine if the request for services is relevant and medically necessary. They will also determine if there are other clinical alternative available to the patient to safely discharge the patient.

2. Clinical Screening is always done by the Dean of Clinical Affairs or Designee for charity requests that are for elective, non-EMTALA charity requests. The request is reviewed for medical relevance, for urgency, and to determine if the request needs to be performed at UCSDHS or if it can be performed at a more appropriate facility.

F. **Payor Code***:* A patient's third party coverage is identified by UCSDHS management information system as the payor code. Payor codes are utilized by UCSDHS to financially and clinical manage a patients account.

G. **"Charity Care Patient"-** A Charity Care Patient is defined as being qualified both financially and clinically. Once qualification is determined, the patient is reviewed for approval to receive care that will be funded, in part or in whole, by UCSDHS. Charity care will be determined in advance of care for non-emergent services and the patient will be aware that the services rendered are charity care or partial charity care.

H. **"Bad Debt"** –Unpaid portion of patient's charges that go unmet. If a financially cleared patient does not provide payment to UCSDHS per the Letter of Agreement (LOA) or their obligations with their 3rd party coverage (health plan or Governmental payor) after reasonable collection effort have been attempted, the Patient's account is considered "Bad Debt" or uncollectable. Bad Debt may also be considered for patients who received unscheduled services that could not be cleared prior to the service being rendered. Scheduled services that are deemed by a non-government payor as not a covered benefit or an un-authorized service may be considered bad debt. Uncollectable accounts are placed with an outside (non-UCSDHS affiliated) collection company to allow for more aggressive collection activities to occur. One or more outside company may be used. These outside companies have been authorized by UCSDHS to report delinquencies to credit reporting agencies if the debtor/responsible party does not make payment of the amount due, or enter into a payment agreement within 150 days of the initial statement date.

I. **"Self-Pay Service"**: A medical service that is not a covered benefit by a third party payor or a service rendered or to be rendered to a patient who does not have third party coverage. A self-pay service may be reviewed for the cash discount, the partial charity and the full charity programs.

J. **"Self-Pay Patient"**: A financially eligible Self-Pay patient is defined as follows:

1. No current 3rd party coverage or a patient that is not eligible for obtaining coverage. This includes a PCIP (Pre-existing Condition Insurance Program) plan for the patients in their state of residences. Section 1011 is not considered 3rd party coverage.

2. No Medi-Cal/Medicaid coverage or patients who qualify but who do not receive coverage for partial services or for the entire course of stay.

3. No compensable injury for purposes of government programs, workers' compensation, automobile insurance, Victims of Crime (VOC) other insurance, or third party liability as determined and documented by the hospital.

K. **"High Medical Cost patient**": A financially eligible High Medical Cost patient is defined as follows:

1. "A patient with high medical costs" means a person whose family income does not exceed 350% of the federal poverty level.
2. Out-of-pocket medical *costs incurred by the individual UCSDHS* in prior twelve (12) rolling calendar months that exceeds 10% of family income.
3. The patient must comply with the all aspects of the charity care program in regards to financial screening and applying for State and Federal Programs.
4. The patient does not receive a discounted rate from the hospital as a result of his or her third-party coverage.

K. **"Medically Necessary Service":** A medically necessary service or treatment is one that is critical for diagnosis or treatment of a patient. Omission or delay of intended service would likely adversely affect the patient's condition, illness, injury and therefore treatment is not considered elective or cosmetic. This is determined solely by a qualified Healthcare provider for urgent and emergent care.

L. **"Patient's Family":** For patients 18 years of age and older, patient's family is defined as their spouse, domestic partner and dependent children under 21 years of age, that are living in the home.. For persons under 18 years of age, patient's family includes a parent, caretaker relatives and other children less than 21 years of age of the parent or caretaker, relative, or guardian living in the home.

M. "**Patient Liability":** The financial responsibility (monies due) that is owed by the patient for the service(s) to be rendered or already rendered. If the patient has a 3rd party payor, the patient liability is determined by the 3rd party payor's policy with the patient. UCSDHSis contractually obligated with the 3rd party payors to attempt to collect the patient liability from the patient or designee. Examples of patient liability are co-payments, deductibles, out-of- pocket maximums, co-insurance and Share of Cost. Patient Liability may also represent the patient's financial responsibility for service rendered in the absence of any identified 3rd party payor. In the absence of a third party payor, the patient may be evaluated for public programs, charity care, or self-pay discounts. Patients will be asked for a deposit towards their patient liability even when they are being referred to the above reference programs.

II. POLICY

UCSDHS provides emergency, outpatient, and inpatient, diagnostic and therapeutic services to the community of San Diego. The ability to provide these services is dependent upon the Health System's history, locations, and the degree to which other San Diego healthcare providers are willing to provide services to all segments of the San Diego community.

In recognition of this, UCSDHS must adhere to a comprehensive patient financial policy which incorporates criteria and procedures associated with assessing and confirming funding sources The UCSDHS Patient Financial Policy has been developed to maintain fiscal viability while providing quality customer service, and consistent and transparent handling of patient accounts.

It is the policy of the UCSDHS staff to determine if an individual seeking services meets the financial policy requirements. Individuals, with non-emergent complaints, who do not satisfy the financial policy requirements, will be deferred/rescheduled until such time as they meet the requirements or will be referred to the appropriate public assistance agencies and/or alternative healthcare providers. UCSDHS is committed to providing emergency services to all individuals based solely on the individual's medical need. It is the policy of the UCSDHS that:

☐ Patients presenting with an **emergency** medical condition will be provided with emergency medical services and care without regard to their ability to pay or their financial status. The financial screening process will begin prior to discharge, but only after medical screening/ treatment has occurred.

☐ All patients seeking non emergent services will be financially screened to identify a source of funding

☐ Estimated patient liabilities will be identified prior to scheduled service. Patients will be given the option to make a payment prior to the service, at the time of service, to be billed after the service is rendered or payment arrangements with these policies guidelines.

All exceptions/appeals must be requested, in writing utilizing the Charity/Clinical Override Request form (D937), reviewed and approved by the Dean of Clinical Affairs or his designee. Tracking and monitoring of physician's requests for Charity and Clinical Override will be monitored for clinical and financial appropriateness. Cases deemed inappropriate may be denied and will be brought to the attention of the Department Chair for periodic review and appropriate action.

This policy is designed to provide assistance to Financially Eligible Patients [statutorily defined term], who require medically necessary services, are uninsured, ineligible for third party assistance or have high medical cost.

This policy will not apply if the patient/responsible party provides false information about financial eligibility or if the patient/responsible party fails to make every reasonable effort to apply for and receive government-sponsored insurance benefits for which they may be eligible.

III. PROCEDURES AND RESPONSIBILITIES

A. COMMUNICATION OF CHARITY CARE AND DISCOUNT POLICIES

Responsibility: Patient Access and Patient Financial Services

- Patients will be provided a written notice as part of their bill that contains information regarding the hospital's charity care policy, including information about eligibility, as well as contact information for a hospital employee, a third party vendor, or office from which the patient may obtain further information about these policies. At the time of service, notices are to be given to all patients that do not appear to have third party coverage, in the Patient Access Department, Emergency Room and other outpatient hospital settings. Notices will be provided in English and in Spanish.

- UCSDHS will train staff regarding charity care procedures related to patient financial assistance.

- Notice of UCSDHS Charity Care Policy is posted in conspicuous places throughout the hospital including the Emergency Department, Admissions Offices, Outpatient settings and the Patient Financial Services Department, in languages as determined by UCSDHS geographical area.

ELIGIBILITY FOR 100% CHARITY CARE

Responsibility: Patient Access

Charity care can be initiated by the patient, the treating UCSD physician or the discharge planning team.

Every effort will be made to screen all patients identified as uninsured or in need of financial assistance. Patient may be identified at the time of admission, in the emergency department or in the outpatient setting. Identified patients are screened for the ability to pay and/or determine eligibility for payment programs, including those offered through the UCSDHS. Screened patients' financial information will be monitored as appropriate. Screened patients will be provided assistance in assessing patient eligibility for Medi-Cal or any other third party coverage.

All potentially eligible patients must apply for assistance through State, County and other programs before UCSDHS will review a Charity Care request. If Sponsorship by a State or Local program is denied, UCSDHS must receive a copy of denial. Failure to comply with the application process or provide required documents is considered in the determination of charity eligibility. Willful failure by the patient to cooperate will result in UCSDHS inability to provide financial assistance**.**

− Patients without third party coverage at or below 200% of the FPL will be extended a 100% charity care discount on services rendered.

− Means testing consists of a review of the patient's income and assets. The Patient Financial Information form (see Form 151-026) is used to determine a patient's ability to pay for services at UCSDHS and/or to determine a patient's possible eligibility for public assistance. This form is available in both English and Spanish.

− The Patient Financial Information form should be completed for all patients requesting a charity care discount. If the screening for Charity Care is not completed while the Patient remains hospitalized, designees of Patient Access and/or Patient Financial Services department will complete the financial screening post discharge at the request of the patient. It is the patient's responsibility to initiate a post-discharge screening request, and to cooperate with the information gathering process.

− Eligibility based on the parameters below is not indicative of Charity being granted, as all cases must be reviewed and by approved by the Dean of Clinical Affairs or his designee:

1. Patients without third party coverage will be financially screened for eligibility into a state and federal governmental programs as well a charity care funding at the time of service or as near to the time of service as possible. The patient will be offered an application for the Medi-Cal program, County Medical Services (CMS), Low Income health Plan (LHIP), the Healthy Families program, California Children's Services (CCS) or state funded governmental program before the patient leaves the hospital, emergency room or other outpatient setting. UCSDHS will provide assistance in the application process for state and federal governmental programs when applicable. Patient-specific information will be provided to the County and State in accordance with County and State guidelines for eligibility determinations for government-funded sponsorship programs.

2. The patient must comply with the public program referral process. This includes signing all documents required by the County of San Diego or the State of California and providing all verification documentation requested by County of San Diego or the State of California,
   If the County of San Diego or the State of California determine the patient has a spend down, the patient must comply with the spend down processes as detailed by County of San Diego or the State of California.

3. The patient must comply with the self-pay guidelines given to the patient at the time of service that states if we do not assist the patient with the public program referral process, the patient is responsible for applying at their location district office within 30 days.

Note: Compliance with a public program referral does not apply to patients who complete the application process and are determined either by County of San Diego or the State of California that they are not eligible due to "No Linkage to a Public Program". These patients may still be evaluated for charity care.

4. Patient's family income is verified not to exceed 200% of FPL for the most recent filed Federal tax return or recent paycheck stubs.

5. First $10,000 of monetary assets (liquid assets) are excluded.

6. Retirement accounts and IRS-defined deferred-compensation plans (both qualified and non-qualified) are not considered monetary assets and are excluded from consideration.

7. Assets above the statutorily excluded amounts will be considered exceeding allowable assets and may result in denial of charity care discounts.

ELIGIBILITY FOR PARTIAL CHARITY CARE FOR PATIENTS WITH NO THIRD PARTY COVERAGE

Responsibility: Patient Access

Partial Charity care can be initiated by the patient, the treating UCSD physician or the discharge planning team.

Patients with no third party coverage with family income between **201% and 350%** of FPL are eligible for partial charity care. The Patient Financial Assistance form should be completed for all patients requesting charity care.

1. Patients without third party coverage will be financially screened for eligibility into a state and federal governmental programs as well a partial charity care funding at the time of service or as near to the time of service as possible. The patient will be offered an application for the Medi-Cal program, County Medical Services (CMS), Low Income Health Plan (LHIP), the Healthy Families program, California Children's Services (CCS) or state funded governmental program before the patient leaves the hospital, emergency room or other outpatient setting. UCSDHS will provide assistance in the application process for state and federal governmental programs when applicable. Patient-specific information will be provided to the County and State in accordance with County and State guidelines for eligibility determinations for government-funded sponsorship programs.

2. The patient must comply with the public program referral process. This includes signing all documents required by the County of San Diego or the State of California and

providing all verification documentation requested by County of San Diego or the State of California. If the County of San Diego or the State of California determine the patient has a spend down, the patient must comply with the spend down processes as detailed by County of San Diego or the State of California.

3. Family income will be verified with either the most recent filed Federal tax return or recent paycheck stubs.

4. Once it is determined that a patient's family income is between 201% and 350% of the poverty level, monetary (assets that are readily convertible to cash, such as bank accounts and publicly traded stock) assets will be considered in the eligibility determination for charity

Once a patient is determined to be eligible for <u>Partial Charity</u>, the amount of the patient liability will be equivalent to Medicare reimbursement. Patient liability amounts will be the equivalent of the reimbursement UCSDHS would receive from Medicare. Patients will be given an estimate of liability based on Medicare rates.

ELIGIBILITY FOR CHARITY CARE FOR HIGH MEDICAL COST PATIENTS WTH THIRD PARTY COVERAGE

High Medical Cost does not apply when UCSDHS is contracted with the patient's third party payor and we received remit for the services that have associated high medical cost. High Medical Costs are generally associated with Catastrophic plans, low benefit plans and services that are not a covered benefit under a patients plan.

Patients with third party coverage with high medical costs (a patient that does not otherwise receive a *discount for the services to be billed as a result of third party coverage*) will be screened by a Financial Counselor in the Admissions Department prior to procedure/admission. Post discharge screening for charity care will be conducted by the customer service unit of PFS.

A *discount for the services to be billed as a result of a third party coverage* includes the contracted rate UCSDHS received from that third party payor. High medical costs do not apply to a patient's deductible, out-of-pocket maximum or co-insurance.

Upon patient request for a charity care discount, the patient will be informed of the criteria to qualify as a High Medical Cost patient and the need to provide receipts if claiming services rendered at other providers in the past twelve months. It is the patient's decision as to whether they believe that they may be eligible for charity and wish to apply. However, the UCSDHS must ensure that all information pertaining to the Charity Care Discount Policy was provided to the patient.

− High Medical Cost patients with third party coverage who are below 200% of the FPL with medical costs in excess of 10 % of the patient's family annual income, and who have not received a discount as a result of third party coverage for the services to be billed, will be extended a 100 % charity care discount on services rendered.

− High Medical Cost patients with third party coverage whose family incomes are between 201% and 350% of FPL with high medical costs are eligible for partial charity care. High medical costs are 10% of annual family income paid for medical costs in the last twelve months.

− Patient is required to provide proof of payment of medical costs. Proof of payment may be verified.

− The Patient Financial Information form should be completed for all patients requesting charity care. High Medical Cost patients need to be evaluated monthly to accurately account for medical cost for the last twelve (12) months.

− Patient's family income will be verified with either the most recent filed Federal tax return or recent paycheck stubs to confirm that the patient's family income is within the charity or partial charity guidelines.

− Assets will be not considered in the determination for charity care or partial charity for this patient population. Eligibility will be based on the patient's family income qualification only.

− Extended payment plan will be interest free up with up to 12 months repayment timeframe (monthly installment payments required).

Like the standard charity care program and the partial charity care program, the patient must comply with the public program referral process. This includes signing all documents required by the County of San Diego or the State of California and providing all verification documentation requested by County of San Diego or the State of California. If the County of San Diego or the State of California determine the patient has a spend down, the patient must comply with the spend down processes as detailed by County of San Diego or the State of California.

At A Glance of Review of Charity Care Policy

	FPL	Is Patient Insured?	Patient Compliant with Public Program Process	Clinical Review	Financial Screening by Patient Access	Approval Required By Dean Or Designee
Full Charity Care	0% to 200%	No	Required	Required	Required	Required
Partial Charity Care	200%-350%	No	Required	Not Required	Required	Required
Charity Care for High Medical Cost Patients	0% to 200% Or 200%-350%	Yes	Required	Not Required	Required	Required
Self pay patients- US residents	Over 350%	No	No	No	Not Required	Not Required
International Patients	Not Applicable	Not Applicable	No	No	Not Required	Not Required

B. SELF PAY (NON-CHARITY) DISCOUNT

Current State Refined:

− For patients with no third party coverage whose incomes are above 350% of the Federal Poverty Level, a 30% discount off of billed charges will be offered for *Service date or Discharge date is before 6/30/12* . This is extended to US Citizens and legal residents residing in the United States
-For patient with no third party coverage whose incomes are above 350% of the Federal Poverty Level, the standard 45% discount off of billed charges will be offered for *Service date or Discharge date is after 7/1/2012.* This is extended to US citizens and legal residents residing in the United States.

− A minimum of 50% of this discounted amount of the estimated charges is paid prior to or on the date of service. The amount collected prior to the date of service is based on the estimate of charges based on the expected services to be rendered. The actual payment expected will be 30% off of billed charges for the services rendered before 6/30/2012 and the actual payment expected will be 45% off of the billed charges for the service rendered after 7/1/2012.

− The remaining 50% payment timeframe will be specified in a LOA. Standard timeframe for repayment is no longer than a period of twelve (12) months. If the remaining 50% is not paid timely as agreed to in the LOA, the discount will be rescinded and the patient will owe the 100% of charges less any prior payments received.

-For patients not residing in the United States (International Patients): Financial screening to establish the patients Federal Poverty Level is not required. Patient will be offered a Self-Pay discount of45% off of billed charges.

A 100% of this discounted amount of the estimated charges is paid prior to or on the date of service. The amount collected prior to the date of service is based on the estimate of charges based on the expected services to be rendered. The actual payment expected will be45% off of billed charges of the services rendered.

CASH PACKAGES

UCSDHS has several cash packages for services that are comprehensive agreements between the patient and UCSDHS. Cash package arrangements must be made prior to the date of service. The required payment of the cash package is outlined in each package contract and must be made per the terms of the contract or the contract is voided and the patient is responsible for the charges in full. Cash packages are only available for patients who do not have 3rd party coverage or the service requested is not a covered benefit.

Current Cash Packages available are:
OB Cash Packages
TAP Cash Package
LAP Band Placement and Revision Cash Packages
PTE Cash Package
Plastics Cash Package (specific package information upon request)

CLINICAL TRIAL PATIENTS

Clinical Trial patients are financially screened by the same process and requirements as a non-clinical trial patient.
The clinical trial coordinator informs Patient Access the patient is being screened for a clinical trial or that the patient has been enrolled into a clinical trial.
At that point, Patient Access is informed of what procedures and/or medications are covered by the trial and what is considered standard of care and is billable to a 3rd party payor. For standard of care, Patient Access will confirm the patient has insurance eligibility, verify the benefit coverage under the patient's plan, and confirm the authorization for the procedure has been secured for the requests service(s). If the patient cannot be fully financially cleared, they will inform the clinical trial coordinator that the patient is not financially cleared. The physician will then have to determine if the patient is to be evaluated for charity care, clinical override or be considered a self-pay patient for standard of care services.
Any services rendered that are covered by the clinical trial will not be the financially responsibility of the patient.

C. REVIEW PROCESS

Responsibility: Patient Access and Patient Financial Services

1. Requirements above will be reviewed and consistently applied throughout the UCSDHS in making a determination on each patient case. The requirements and polices detailed here within are applied for pre-service, point of service and post service requests.

2. Information collected in the Patient Financial Assistance form may be verified by UCSDHS. A waiver or release may be required authorizing the hospital to obtain account information from a financial or commercial institution or other entity that holds or maintains the monetary assets to verify their value. The patient's signature on the Patient Financial Assistance form will certify that the information contained in the form is accurate and complete.

3. Any patient, or patient's designated representative, who requests a charity care discount under this policy shall make every reasonable effort to provide the hospital with documentation of income, any 3rd party coverage and any required verifications requested by the County of San Diego or the State of California and all health benefits coverage. Failure to provide information may result in denial of charity care.

4. Eligibility will be determined based on patient's family income including monetary assets as outlined in Title 6, Civil Rights Act of 1964, Assembly Bill 774, Health & Safety Code Section 127400 et al, Hospital Fair Pricing Policy, and the OIG guidance regarding financial assistance to uninsured and underinsured patients.

5. The Patient Financial Information will be required each time the patient is admitted and is valid for the current admission plus any other outstanding patient liability at UCSDHS time of determination. The inpatient application can be used in the determination of charity care for outpatient services. Outpatient charity approvals are specific to only those services detailed on the charity approval. Any additional services are recommended or ordered by the treating physician may result in a new charity application and patient financial screening.

6. Patient will be notified in a timely fashion of approval or reason for denial of charity care eligibility in languages as determined by UCSDHS geographical area pursuant to federal and state laws and regulations.

7. Patients who have been approved partial charity, an estimate of patient liability will be generate based on the treating physician orders. This estimate will be based on Medicare rates for the planned service(s). This estimate may be for a single episode of care or for an entire treatment plan. The estimate is based on anticipated services and is priced to enable accuracy of federal healthcare program reimbursement reporting.

8. For patients with third party coverage with high medical costs seeking charity or partial charity care, it may be necessary to wait until a payer has adjudicated the claim to determine the patient's financial liability.

D. ADMISSIONS & REGISTRATION PROCEDURES

Responsibility: Patient Access

INPATIENT SERVICES

The Patient Access department will be responsible for the financial screening (refer to Section 1, Part D for financial screening details), and the scheduling of all inpatient admissions. Admissions to UCSDHS shall be classified into three major categories:

1) scheduled; 2) unscheduled; and, 3) transfers.

SCHEDULED

1. A completed Request for Admission will be submitted to the Admissions Department at least three working days prior to the scheduling of an inpatient admission and/or related inpatient procedure(s).

2. Patient Access will complete a financial screening within two working days of receipt of a

Request to Admit form. The request to admit must have the anticipated/ordered procedures, the admitting diagnosis and all relevant procedural data (such as expected time in the Operating Room, expected Anesthesia Time, any necessary devices, etc.). The service request is submitted through the patient's electronic medical records.

3. If a patient does not meet UCSDHS financial policy requirements, the Patient Access representative will refer the patient to the appropriate health care or medical assistance resources. The Patient Access Representative will notify the admitting physician of the reason(s) for deferring the admission. If the Physician determines that the patient's requested service cannot be deferred, the Patient Access Representative will discuss the option of either screening the patient for charity care or enact the physician clinical override policy. If the physician determines the service request is medically necessary and cannot be deferred, and a clinical override is initiated, the patient and the treating physician will be notified that the patient may be financially responsible for the services that are rendered. UCSDHS will make every effort to financially clear the patient even after the clinical override has been obtained. If the patient cannot be financially cleared and therefore is responsible for the charges of the services rendered, the patient will be screened for charity care, partial charity, or self-pay discounts.

4. If the patient does meet UCSDHS financial policy requirements, the Financial Counselor will obtain the necessary patient liability deposits, make payment arrangements and ensure compliance with the payor's authorization requirements. The admission of the patient is completed based on the admitting physician's request. To be considered Financially Cleared for admission:

   a. Self-Pay Patient: Patient must sign letter of agreement (LOA) detailing out the *estimate of patient financial liability on the service requested* by the treating physician, and the timeline for repayment. They must also place at minimum of 50% of the estimate of charges prior to service.
   b. Insurance Patients: Eligibility, benefits and pre-certification/authorizations are verified, and all patient liabilities (co-pay/other share of cost) are collected, including any balances still owing for prior services. Arrangements for payment of patient liabilities can be done in lieu of pre service payments.
   c. Patients will be referred to financial counselors for any inability or refusal to pay outstanding liabilities of $500 or more.

5. If the patient or guarantor is unable to pay the balance of the patient liability at the time of discharge, the payment of the patient liability will be due within thirty (30) days of receipt of the initial billing. At that time, the patient will receive a statement of outstanding liability.

6. UCSDHS will bill foreign governments if arrangements are made in advance; however, it is the patient's responsibility to bill foreign insurance companies.

UNSCHEDULED

Unscheduled admissions will be classified into two categories: 1) emergent and 2) non-emergent.

1. **Emergent Admissions**

a. The patient or the patient's representative will be financially screened within 48 hours of admission.

b. If it has been determined that a patient does not meet UCSDHS financial policy requirements, the Financial Counselor will initiate a referral to the appropriate public program or medical assistance agencies. (Medi- Cal, Medicare, CMS, CCS, GHPP, LHIP). In accordance with the County of San Diego regulations, initiation of the public program referral process will be done only after the patient has been designated as an inpatient for 24 hours. If the patient is not designated as an inpatient or was inpatient for less than 24 hours, UCSDHS will make every effort to assist the patient will the referral process through the district office.

c. In Addition to initiating and assisting the patient in the public program referral process, the Financial Counselor will make payment arrangements for the estimated patient liability and ensure compliance with the payors authorization requirements. The patient has the right to refuse to be referred to a public program or a medical assistance agency. Such refusal would affect the patient's qualification for charity care. The patient will be informed at such time that they will not be eligible for charity care, but could still be offered the self-pay discount.

2. **Non-Emergent Unscheduled Admissions**

a. A completed Request for Admission will be submitted through the patients electronic medical record and confirmed by Patient Access Department at the time the patient arrives.

b. A Patient Access Representative will financially screen the patient.

c. If it has been determined that a patient does not meet UCSDHS financial policy requirements, the Financial Counselor will refer the patient to the appropriate health care or medical assistance resources. The Financial Counselor will notify the admitting physician of the reason(s) for deferring the admission. Charity Care/Clinical Override discussion will occur with the Admitting Physician. If the Admitting Physician requests a Clinical Override, the patient and physician will be made aware they are still financially liable for the services rendered.

d. If it has been determined that a patient does meet UCSDHS financial policy requirements, the Financial Counselor will obtain the necessary patient liability deposits, make payment arrangements and ensure compliance with the payor's authorization requirements.

TRANSFERS

All Transfer Admissions will be handled in accordance with UCSDHS Transfer Policy and Procedures.

1. For Non-EMTALA Transfers: The Transfer Center is responsible for obtaining all necessary clinical and any available financial information at the time the request for transfer is initiated. Patient Access will work with the Transfer Center and the referring facility to financially screen the patient prior to the patient coming to UCSDHS. This includes, but is not limited to, eligibility, benefits, ensure that the transferring facility has secured the authorization for the transfer and faxed the facesheet to the 3rd party payor if necessary. It is the responsibility of the transfer center staff to obtain the transfer agreement between UCSDHS and the transferring facility.

2. The Transfer Center will determine whether or not UCSDHS has a contractual obligation to approve the transfer. The Patient Access representative serves only determine if the patient meets UCSDHS financial policy requirements.

3. The Transfer Center Clinical Team will inform the physician who is performing the medical evaluation of the transfer request under what circumstances the transfer may or may not be approved. Discussion regarding Charity Care/Clinical Override will occur for patients without funding prior to acceptance of case. A Transfer Back Form will be sent to the transferring facility for signature signifying agreement to take patient back when specialized care is rendered and patient is stabilized.

4. All transfer requests, which have been accepted, based solely on the level of care criteria will be documented appropriately and presented to the Director of Patient Access. Financial screening will occur after the patient has been transferred to UCSDHS.

OUTPATIENT SERVICES

Outpatient Surgeries/Invasive Procedures/Ancillary Services

1. All new patients seeking the above mentioned outpatient services will be registered prior to receiving services. This includes the collection and review of the patient's demographic and financial information.

2. If it has been determined that a patient meets UCSDHS financial policy requirements, the patient will be instructed to present the appropriate documentation of coverage in advance of their appointment.

3. Returning patient's information will be re-verified for each service as part of the Financial Clearance process in advance of services being rendered.

4. If it has been determined that the individual does not meet UCSDHS financial policy requirements, the appointment will be deferred and the individual will be referred to the appropriate health care or medical assistance resources.

Emergency Department Services

1. All patients with emergent conditions will be treated without regard to their ability to pay in accordance with EMTALA. Emergency Department Registration Staff is responsible for the collection of patient financial and demographic information. This information may be collected while the patient is waiting for treatment, but will not be used in determining the order in which patients are screened and stabilized.

2. If the information cannot be obtained while patient is waiting for care, it will be collected at the point of patient discharge from the Emergency Department. Emergency Department Registration Staff will also routinely collect deposits and co-payments for services rendered in the Emergency Department.

E. PATIENT BILLING AND COLLECTION PRACTICES

Responsibility: Patient Financial Services

1. Patients who have not provided proof of coverage by a third party at or before care is provided will receive a statement of charges for services rendered at the hospital. Included in that statement will be a request to provide the hospital with health insurance or third party coverage information. An additional statement will be provided on the bill that informs the patient that if they do not have health insurance coverage, the patient may be eligible for Medi-Cal, Healthy Families, California Children's' Services or charity care.

2. Patient's requests for information about UCSDHS Charity Care policies can be communicated verbally or in writing and a Patient Financial Information packet will be given/mailed to patient/guarantor address. Written correspondence to the patient shall also be in the languages as determined by UCSDHS geographical area pursuant to federal and state laws and regulations.

3. Patients are required to report any change in their financial information to UCSDHS in a timely manner.

4.UCSDHS or its contracted collection agencies will undertake reasonable collection efforts to collect amounts due from patients. These efforts will include assistance with application for possible government program coverage, evaluation for charity care, offers of no-interest payment plans, and offers of discounts for prompt payment. UCSDHS is entitled to pursue reimbursement from third party liability settlements or other legally responsible parties.

5. Agencies that assist the hospital and may send a statement to the patient must sign a written agreement that it will adhere to the hospital's standards and scope of practices.

6. The agency must also agree to:

☐ Not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days from the date the initial statement is mailed to the patient/responsible party.

☐ Not place liens on primary residences.

☐ Adhere to all requirements as identified in AB774 (Health & Safety Code Section 127400 et seq).

7. In the event that a patient is overcharged, the hospital shall reimburse the patient the overcharged amount with 7 % interest (Article XV, Section 1 of the California Constitution) calculated from the date the patient made the overpayment.

F. APPEALS/REPORTING PROCEDURES

Responsibility: Patient Financial Services

1. In the event of a dispute or denial, a patient may seek review from the Customer Service Manager. The senior leadership of the Patient Financial Services Department will review a second level appeal if needed or requested by the patient.

2. The Charity Care policy, Discount Payment policy, and Patient Financial Information form shall be provided to the Office of Statewide Health Planning and Development (OSHPD) at least biannually on January 1, or with significant revision. If no significant revision has been made by UCSDHS since the policies and financial information form was previously provided, OSPHD will be notified that there has been no significant revision.

3. Questions about the implementation of this policy should be directed to the Director of Patient Financial Services at 619-543-3055. Questions about Financial Assistance eligibility should be directed to the Financial Counseling Manager at 619-543-3989 and Credit and Collections Manager at 619-543-7072.

AN EXCEPTION – A PATIENT RECEIVING CARE WITHOUT BEING FINANCAILLY CLEARED

A Patient may be approved due to extenuating circumstances (based upon clinical information provided by the patient's referring and/or attending physician). A Clinical Override form will be submitted to the Dean of Clinical Affairs for review and approval

If an exception to the Patient Financial Policy requirements is approved by UCSDHS and the patient/patient's designee, the agreement is only applicable to the services documented in the Letter of Agreement (LOA). Approved exceptions are not applicable to future services not explicitly stated in the LOA nor does an approved exception apply to previous visits.

IV. FORMS

Charity/Clinical Override Form (D 937)
Financial Screening Form (151-026)
Notice of Hospital Policy for Charity and /or partial Charity Care (D455)

V. ATTACHMENTS

None.

VI. REGULATIONS:

-- Title 6, Civil Rights Act of 1964
-- California Health & Safety Code section 127400 et seq. (AB 774)
-- Hospital Fair Pricing Policies, effective January 1, 2007,
--Office of Inspector General, Department of Health and Human Services ("OIG") guidance regarding financial assistance to uninsured and underinsured patients. Section 1866, 1867, Social Security Act , United States Code, Title 42, Section 1395dd

VII. APPROVALS

This policy and procedure was approved by the following committee(s):

Committee Name:	Date Approved:
Senior Management Team	June 13, 2012

Original approved date: 10/1/1992

Revision date(s): 10/18/1998
9/5/2001
10/13/2004
3/4/2009
4/28/2010
6/13/2012