Laguna Honda Hospital & Rehabilitation Center
Admissions & Eligibility Department

Policy Number 06-01

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Charity Care and Discount Payment Policy and Procedure

POLICY: As of January 1, 2007, Laguna Honda Hospital (LHH) will offer a Charity Care and Discount Payment Program consistent with the provisions of Assembly Bill No. 774 (AB774). It is the policy of LHH to initially provide medical care to indigent individuals regardless of their ability to provide reimbursement after considering other sources of reimbursement such as; third party liability coverage, government programs, and Charity Care.

The Charity Care and Discount Payment Programs are available to assist uninsured or underinsured patients with limited income of up to 350% Federal Poverty Level (FPL), and who are not eligible for any other state, federal, outpatient, acute or LTC programs including third party liability.

Effective January 1, 2015 Laguna Honda Hospital (LHH) will amend this policy per Senate Bill No. 1276 (SB1276) legislation providing that the hospital shall:

- Change the definition of a person with high medical costs to include those persons who do receive a discounted rated from the hospital as a result of 3rd party coverage.
- Use a specified formula to create a reasonable payment plan, as defined, if the hospital and the patient cannot agree to a payment plan.
- Negotiate with a patient regarding a payment plan, taking into consideration the patient's family income and essential living expenses.
- Reasonable payment "formula" 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.
- Provide patients with a referral to a local consumer assistance center housed at "Legal Services Offices."

Description: The procedure describes the process to identify and secure all available third party coverage and government programs, and to make the Charity Care and Discount Payment Programs and Reasonable Payment Plan available to self-pay or high medical cost patients as defined in AB77r and SB1276

It is the intent of this policy to comply with all federal, state, and local regulations. If any regulation, current or future, conflicts with this policy, the regulation will supersede this policy.

I. CHARITY CARE:

A. Definition of Charity Care:

Charity Care is a term used to describe medically necessary services provided at a reduced cost, or at no cost to indigent individuals who are uninsured. Assuming all eligibility requirements are met, patients utilizing service provided at the Laguna Honda Hospital Acute and /or Rehabilitation facilities as well as SNF care are applicable to this program. Charity Care will be offered to uninsured and underinsured patients with income levels not exceeding 350% of the FPL, and qualified assets in accordance with AB774.

Underinsured is defined as a patient who is insured but has "high medical costs", and who is at or below 350% of the FPL.

A patient's qualifying assets must not exceed $250.00 at the time of service, as defined in AB 774. According to AB774, the first ten thousand dollars ($10,000.00) of a patient's monetary assets shall not be counted in determining eligibility. Nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000.00) be counted in determining eligibility. Assets are considered to be: cash; checking accounts; savings accounts; money market funds; certificates of deposits; annuities; stocks, bond or mutual funds that are not part of a retirement or deferred compensation plan qualified under the Internal Revenue Code, or non qualified deferred – compensation plan.

B. **Requirements to apply for Charity:**

1. Patient must comply in a timely manner with screening process by providing all required information on other coverage, including pursuing third party liability.

2. Patient must apply for government programs for which he or she is potentially eligible. Patients who do not cooperate will not be eligible.

3. Patient must complete an application and provide required verifications as follows:

    a) Most recent 3 months of patient's income stubs before the date of the Charity or last income tax return.

    b) Last 3 months of bank, or brokerage account statements from date of Charity Care Application.

4. Patients with income levels at or below 100%, FPL will be charge a patient liability. Patients with income above 100% up to 350% FPL will receive varying Charity Care discounts. Current patient liability rates are reflected on the Charity Care Payment Rate Chart.

5. Patients who decline to provide asset information will be evaluated only for the Discount Payment Program.

6. Services that are part of a package program are provided at a discounted rate and are not eligible for the Charity Care or the Discount Program.

C. **Requirements for Patients with High Medical Costs:**

1. Patients with High Medical Costs must meet the criteria listed under Charity Care. In addition, the patient must meet one of the following conditions to receive Charity Care:

a) Annual out of pocket costs incurred by the individual at the hospital that exceed 10 percent of the patient's family income in the prior 12 months.

b) Annual out of pocket expenses that exceed 10 percent 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 12 months.

c) Patient who do receive a discounted rated from the hospital as a result of 3rd-party coverage.

d) Patient must meet Charity Care criteria for qualifying asset.

II. DISCOUNT PROGRAM

A. **Definition of Discount Program:**

1. Discounts will be offered to uninsured and underinsured patients with income levels not exceeding 350% of the FPL and patients who do not qualify for Charity Care in accordance with AB774.

2. Underinsured is defined as a patient whose insured with "high medical costs" and income levels not exceeding 350% of the FPL.

3. An insured or underinsured patient may also qualify for a Discount Payment if they meet the above criteria and one of the "high medical cost" conditions.

B. **Requirements for Discount:**

1. Patient must comply in a timely manner with the screening process by providing all required information on other coverage; including pursuing third party liability. Patient must also apply for government programs which he or she is potentially eligible for in a timely manner. Patients who do not cooperate will not be eligible.

Patients who later apply or are approved for government programs with coverage that does not extend retroactive to the hospital date of service for the amount owed may apply for the hospital discount program, but will not be eligible for Charity Care Program.

2. Patient must complete an application and provide the required verifications as follows:

   a) Most recent 3 months of patient's pay stubs before the date of the application or last income tax return.

3. Determination that patient is ineligible for Charity Care due to excess qualifying assets.

C. **Requirements for Insured or Underinsured Patients with High Medical Costs:**

1. Insured Patients with High Medical Costs must meet the criteria of the Discount Program. In addition, the patient must meet one of the following conditions to receive a discount:

2. Annual out of pocket costs incurred by the individual at the hospital that exceed 10 percent of the patient's family income in the prior 12 months.

3. Annual out of pocket expenses that exceeds 10 percent 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 12 months.

4. Patient is ineligible for Charity Care due to excess qualifying assets.

III. Payment Rates for AB774 Charity Care and Discount Payments:

A. AB774 Charity Care Payment - Charity Care Table

IP or OP	Full Description/ FPL	Patient Liability
OP	Charity Care 0% - 133%	No patient liability
OP	Charity Care 134% - 200%	20% of patient liability up to a cap of $500.00 per Outpatient account
OP	Charity Care 201% - 350%	25% patient liability up to a cap of $1000.00 per Out patient account
ACUTE	Charity Care 0% - 100%	Charges written off, less patient liability.
ACUTE	Charity Care 101% - 200%	60% of DRG
ACUTE	Charity Care 201% - 350%	80% of DRG
LTC	Charity Care 0% - 100%	Zero patient liability for first 15 days of Long Term Care.
LTC	Charity Care 0% - 100%	Thirty-five dollars per day after first 15 days of Long Term Care.

LTC	Charity Care 101%-180%	$50.00 per day
LTC	Charity Care 181% - 250%	$150.00 per day
LTC	Charity Care 251% - 350%	$300.00 per day

B. **AB774 Discount Payment - Discount Table**

IP or OP	Full Description /FPL	Patient Liability
OP	Discount Program 0% - 350%	30% of Charges (A cap of $3,000) per Outpatient account
ACUTE	Discount Care 0% - 350%	Medicare DRG Rate
LTC	Discount Care 0% - 100%	$300.00 per day
LTC	Discount Care 101% - 180%	$350.00 per day
LTC	Discount Care 181% - 250%	$400.00 per day
LTC	Discount Care 250% - 350%	$450.00 per day

C. Patients may request an extended payment plan for any amount due and must make regular payments. Patients who do not comply are sent to collections, may have adverse information reported to a consumer credit agency, and are subject to property liens, excluding their primary residence.

IV. Procedure:

Patients are interviewed by Eligibility to collect demographic, financial and existing insurance information used in the determination of federal, state and county program eligibility.

A. Collect existing Insurance and Third Party Payer Information
   1. Commercial HMO/PPO
   2. Medicare
   3. Medi-Cal and Medi-Cal Special Programs
   4. Slip and Falls/Third Party
   5. Auto Accidents
   6. Injuries at work

B. Refer Patients for County and State Programs Referrals based on:
   1. Provider referral
   2. Request from Patient, Family Member, or Conservator as a result of information provided
   3. The Eligibility Workers determination at the time of registration or admission.

C. Distribution of Governmental Program Applications:

1. Financial Counselors will submit government applications as appropriate to the Medi-Cal Program, The County's Sliding Scale programs, or other government programs as appropriate.

2. Financial Counselors will track and identify patients who were previously referred to apply for Medi-cal and have a Medi-Cal application pending.

3. Notice of the hospital's policy for financially qualified and self-pay patients will be clearly and conspicuously posted and visible to the public in The Admitting and Eligibility Department.

4. The Charity Care and Discount Payment apply to hospital bills for services provided to patients who are self-pay or insured patients with high medical costs.

5. The Financial Counselor will review the eligibility history of the patient's account to verify that the patient has no third party payers and has completed the eligibility process for all government programs for which they may be eligible.

6. If the Financial Counselor determines the patient is self-pay or insured with high medical costs, the patient completes a combined application for the Charity Care and Discount Payment.

D. Assist Patients with Enrollment and Applications:

Patients are referred to programs based on specific diagnosis and/or family demographics. Financial Counselors/Senior Eligibility Workers are available to enroll patients immediately in programs whenever possible. Financial Counselors enroll or assist patients to apply for the following programs:

1. Medi-Cal

2. County Charity Program

3. AB774 Charity and Discount Payment Program

E. Charity Care and Discount Payment is only available as last resort:

1. Financial Counselors must exhaust all third party payer sources, linkages to third party payer sources and the County Charity Program before enrolling a patient for AB774 Charity care or Discount Payment.

F. Required Verifications of Income and Assets:

1. Income (one of the following):

- Most recent 3 months of patient's pay stubs before the date of application or last income tax return.

2. Assets:

- Provide last 3 months of bank, or brokerage account statements from date of application

- Provide bank or brokerage account statements for the quarter period before the date of service. If a patient declines to provide assets information, he or she will then be evaluated for the Discount Program only.

G. Third party coverage:

1. Third party insurance information

2. Auto insurance or liability information

3. Denial notices for government programs

4. Results of lawsuits

H. Notification of Eligibility Determination

1. The patient has 30 days to provide the requested verifications. If the patient fails to provide the verification in 30 days, the application is denied.

2. 2. When an application is complete, the Financial Counselor first evaluates the patient for Charity Care. If the patient if ineligible, the patient is evaluated for the Discount Payment.

3. 3. When an application is complete, the Financial Counselor makes a determination of eligibility and notifies the patient and the Business Office.

I. Notification to Patient

1. Approvals:

The Eligibility Worker will provide the patient or legal guardian a copy of the Charity Care determination notice in person or by mail. . A copy of the approval notice indicating percentage of write-off will be filed in the eligibility department for file record and reference.

2. Denials

The E.W. will document the denial reason for the request for Charity Care and provide the patient or legal guardian with a copy of the document. A copy of the denial notice will be filed in the eligibility department for file record and reference.

J. Notification to Business Office

1. The Financial Counselor forwards a copy of the application to the Business Office for appropriate adjustments on inpatient accounts.

2. Once the billing Office receives the Charity Care/Discount Program screening form, the following information is recorded in the Billing Department's Charity Care Log:

- Patient's Name
- Hospital Registration Number
- Dates of Service
- Date application was approved or denied
- Admitting service and Admitting Source
- Adjustment Amount

K. Eligibility Appeals Process

1. The patient or the patient's representative may appeal the denial and must submit written request within 15 business days of receiving their denial determination to the Eligibility Manager.

2. The patient must submit the following items:
    - Copy of complete application
    - Statement requesting reason for review

    Mail Appeal to:
    Attention: _____**,** Eligibility Manager
    Laguna Honda Hospital
    375 Laguna Honda Blvd., San Francisco, Ca. 94116
    Admitting & Eligibility Department, Unit C5,
    San Francisco, CA 94110

3. The Eligibility Manager reviews the application to verify if the determination is consistent with the Charity Care and Discount Payment policy. The manager notifies the patient in writing of the final decision.

L. Monitoring and Review Process

Once a month the Supervisor of the Admissions Office, and Billing Office will ensure the following:

- Notices are visible to all patients
- Patients with outstanding bills are given an Informational Notice to contact the Financial Counselors Office
- Applications are available on site
- Audit approved and denied applications