

Title: Charity Care, Discount Payment and Catastrophic High Medical Expense Program Policy and Procedure	Department: Patient Financial Services
Reviewer: Diana Guevara	Original Date: December 14, 2006 Revise date(s): March 8, 2007, September 12, 2007; December 14, 2007; June 22, 2008; June 1, 2009; July 15, 2009; April 1, 2011; April 1, 2012; April 1, 2014; January 1, 2015; July 15, 2016

Policy: As of January 1, 2007, Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) will offer a Charity Care and Discount Payment Program consistent with the provisions of Assembly Bill No. 774 (AB774). As of September 17, 2007, the Community Oriented Primary Care Clinics (COPC) are included to offer a Charity Care and Discount Payment Program consistent with the provisions of Assembly Bill No. 774 (AB774). As of November 1, 2010 ZSFG offers the Catastrophic High Medical Expense Program. It is the policy of ZSFG and COPC to initially provide care under the Sliding Scale Program, third party 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 the Sliding Scale Program, government programs, or other payers including third party liability.

The Catastrophic High Medical Expense Program is available to assist uninsured or underinsured patients ineligible for Sliding Scale, Charity Care or Discount Payment Programs with medical expenses exceeding 120 percent of their household annual income and who are not eligible for the Charity Care and Discount Payment Programs, Sliding Scale Program, government programs, or other payers including third party liability.

This Policy applies to services that do not qualify for other discount packages or programs. Package programs such as the hospital’s maternity package, abortion services package or other package programs that are provided to patients at a global rate with significant discounts below government rates are not subject to additional discounts. All accounts with patient liability within 12 months of date of application will be considered.

Effective January 1, 2015 Zuckerberg San Francisco General Hospital and Trauma Center amended this policy per Senate Bill No. 1276 (SB1276) legislation providing that:

- The definition of a person with high medical costs includes those persons who do receive a discounted rate from the hospital as a result of 3rd-party coverage
- The hospital shall negotiate with a patient regarding a payment plan, taking into consideration the patient’s family income and essential living expenses.
- The hospital shall determine a reasonable payment formula where monthly payments are not more than 10 percent of a patient’s family income, excluding deductions for essential living expenses.
- If the hospital and the patient cannot agree to a payment plan, the hospital shall use the specified formula of deducting 60% for essential living expenses from patient’s gross household income and then calculate 10% of the remaining income to determine a reasonable monthly payment amount., The hospital provides patients with a referral for assistance to the Health Consumer Alliance at (888) 804-3536 or The Health Consumer Center/Bay Area Legal Aid at (855) 693-7285.

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 AB774 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 PROGRAM:

A. Definition of Charity Care:

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; Real Estate property that is an income generating property or is not the primary residence; 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 has 30 days from receipt of application to provide 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 pay stubs from date of the Charity application or last income tax return. Income on last tax return is divided by 12 months to identify the monthly income.
 - b. Last 3 months of bank or brokerage account statements from date of Charity application.
 - c. Healthy San Francisco enrolled applicant may replace item (a) requirement with Proof of Income submitted to Healthy San Francisco.
 - d. Applicants enrolled and active with City and County of San Francisco General Assistance Program may replace item (a) and item (b) with current eligibility in the General Assistance Program. Applicant qualifies for Charity care.
 - e. Applicants enrolled and active with County Medical Services Program (CMSP) may replace item (a) and item (b) with current eligibility in the CMSP program. Applicant qualifies for Charity care.
 - f. Patients with ZSFG admission who cooperate with applying for Medi-Cal, may substitute Medi-Cal application and verification for Charity Program application.
4. The patient’s FPL is determined and used on a three-tiered system to determine the qualifying charity program extended to patients. Patients with income levels at 0% - 138%, 139% to 200% and 201% to 350% FPL will receive varying Charity Care discounts referenced in Section III of this policy (refer to grid for discount).
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 requirements listed in (Part I. Sect. B Paragraphs 1-3, and also meet one of the following conditions to receive Charity Care:
 - a. Annual out of pocket costs incurred by the individual at the hospital must exceed 110 percent of the patient's family income in the prior 12 months.
 - b. Annual out of pocket expenses that exceed 110 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. **Patients who do receive a discounted rate from the hospital as a result of 3rd-party coverage**
 - d. Patient must meet Charity Care criteria for qualifying assets.

II. DISCOUNT PAYMENT 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 who do not qualify for Charity Care in accordance with AB774.
2. Underinsured is defined as a patient who is insured with "high medical costs" and income levels not exceeding 350% of the FPL.
3. Patients who do receive a discounted rate from the hospital as a result of 3rd-party coverage.
4. 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 as defined in Part I, Sect. C, paragraph 1, bullet a and b.

B. Requirements for Discount:

1. Patient has 30 days from receipt of application to provide 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.
2. Patients who later apply for government programs or are later approved for government programs, but the coverage 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 the Charity program.
3. Patient must complete an application and provide the required verifications as follows:
 - a. Most recent 3 months of patient's pay stubs from date of the application or last income tax return. Income on last tax return is divided by 12 months to identify the monthly income.
 - b. Healthy San Francisco enrolled applicant may replace item (a) requirement with Proof of Income submitted to Healthy San Francisco.
4. Patient is ineligible for Charity Care due to excess qualifying assets.

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

1. Patients with High Medical Costs must meet the requirements listed in Part II. Sect. B Paragraphs 1-3 and meet one of the following conditions to receive a discount.
 - a. Annual out of pocket costs incurred by the individual at the hospital that exceed 110 percent of the patient's family income in the prior 12 months.
 - b. Annual out of pocket expenses that exceed 110 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.
2. Patient is ineligible for Charity Care due to excess qualifying assets.

III. CATASTROPHIC HIGH MEDICAL EXPENSE DISCOUNT PROGRAM

A. Definition of Catastrophic High Medical Expense

1. Patients must meet one of the following conditions to be considered for Catastrophic High Medical Expense Discount Program
 - a. Annual out of pocket costs incurred by the individual at the hospital must exceed 120 percent of the patient's gross family income in the prior 12 months
 - b. Annual out of pocket expenses that exceed 120 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

B. Requirements for Catastrophic High Medical Expense Program

1. Patient must meet all of the following conditions to qualify for Catastrophic High Medical Expense Discount Program
 - a. Patient is ineligible for Sliding Scale Program, Charity Care or Discount Payment Program
 - b. Patient's gross family income is above 350% FPL
 - c. Applicants must submit a completed Catastrophic High Medical Expense Patient Discount Program application and provide most recent quarter's pay stubs or most recent year tax return statement

Refer to the *Charity Care, Discount Payment and Catastrophic High Medical Expense Program Patient Discount Charts Policy and Procedure* for discounts and patient liabilities per program when eligibility is determined.

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. Healthy Kids
5. Healthy Workers
6. Slip and Falls/Third Party
7. Auto Accidents
8. Injuries at work

B. Refer Patients for County and State Programs Referrals based on:

1. Provider referral
2. Patient's request as a result of information provided
3. Eligibility Worker's determination at time of registration or admission

C. Distribution of Governmental Program Applications

Uninsured and underinsured patients will be provided with a government application as appropriate, the Medi-Cal Program, the County's Sliding Scale program or other governmental program to the patient. This application will be provided prior to discharge if the patient has been admitted or made available to patients receiving emergency or outpatient care.

Medi-Cal Trackers will track and identify patients who were previously referred to apply for Medi-Cal and have a Medi-Cal application pending. These patients will not be provided another government application but will be encouraged to follow through with the pending application.

Notice of the hospital's policy for financially qualified and self-pay patients will be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to all of the following:

- Emergency department registration
- Outpatient registration sites
- Billing office
- Admissions office

Financial Counselors will provide patients with a written notice that shall contain information about availability of the hospital's charity care and discount payment policies, including information about eligibility, as well as contact information for an office from which the person may obtain further information about these policies. The notice shall be provided to patients who receive and may be billed for emergency department care, outpatient care or inpatient care.

The Business office sends out notices with bills as required by AB 774.

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

Patient who receives a bill and declares an inability to pay or requests a bill adjustment at any time within 150 days from initial receipt of bill will be referred to a Financial Counselor to review patient's qualifying eligibility for Charity or Discount.

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.

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 are available by appointment or drop-in to enroll patients immediately in programs whenever possible. Financial Counselors enroll or assist patients to apply for the following programs and insurance:

1. Medi-Cal
2. Hospital Presumptive Eligibility Program
3. Covered California
4. Healthy Kids
5. California Children Services
6. AIDS Drug Assistance Program (ADAP)
7. Child Health & Disability Prevention Gateway to Health Coverage
8. Family Planning Access, Care and Treatment Program
9. Every Woman Counts
10. Breast and Cervical Cancer Treatment Program (BCCTP)
11. Presumptive Eligibility Medi-Cal for Pregnant Women
12. California Victim Compensation Program
13. Healthy San Francisco
14. Sliding Scale Program
15. Charity Care and Discount Payment

E. Charity Care, Discount Payment are only available as last resort

Financial Counselors must exhaust all third party payer sources, linkages to third party payer sources and the Sliding Scale Program before enrolling a patient for Charity Care or Discount Payment.

Catastrophic High Medical Expense Patient Discount Program

Manager will screen Catastrophic Medical Expense applications and verification after determined ineligible for Charity Care or Discount Payment.

F. Required Verifications of Income and Assets

1. Income (one of the following):

- a. Most recent 3 months of patient's pay stubs from date of application or last income tax return. Income on last tax return is divided by 12 months to identify the monthly income.
- b. Healthy San Francisco enrolled applicant may replace item above requirement with Proof of Income submitted to Healthy San Francisco.
- c. Applicants enrolled and active with City and County of San Francisco General Assistance Program may replace meet the income and assets limit for Charity care. Applicant qualifies for Charity care.
- d. Applicants enrolled and active with County Services Medical Program (CMSP) may replace item (a) and item (b) with current eligibility in the CMSP program. Applicant qualifies for Charity.

- e. Patients with ZSFG admission, who cooperate with applying for Medi-Cal, may replace application with Medi-Cal application and verification.

2. Assets:

- a. Last 3 months of bank, or brokerage account statements from date of application.
- b. Bank or brokerage account statements for the quarter period before the date of service.
- c. If a patient declines to provide assets information, he or she will then be evaluated for the Discount Program only.
- d. Patients with ZSFG admission, who cooperate with applying for Medi-Cal, may replace asset verification with Medi-Cal verification.

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. When an application is complete, the Financial Counselor first evaluates the patient for Charity Care. If the patient is ineligible, the patient is evaluated for the Discount Payment.
- 3. When an application is complete, the Financial Counselor makes a determination of eligibility and submits to the supervisor.
- 4. Review and confirmation of the eligibility determination made by the Financial Counselor is conducted by:
 - a. Eligibility and Enrollment Supervisor for all outpatient accounts
 - b. Inpatient Supervisor and Manager review all applications with an inpatient account before notification.
- 5. After review, the Financial Counselor notifies the patient and the Business Office.

I. Notification to Patient

1. Approval

The Financial Counselor will complete the insurance revisions of the accounts and refer account balances to the business office for appropriate adjustments. The patient will receive a new statement reflecting the revised patient liability amount.

2. Denial

The Financial Counselor completes the eligibility determination portion of the application. The Financial Counselor provides the patient with a copy of the denial notification and the information of the appeals process.

J. Notification to Business Office

1. Approval

- a) All accounts with patient liability within 12 months of date of application will be considered.
- b) The Financial Counselor revises the accounts approved for the discount by changing the insurance plan code.
 - Ward 24 Financial Counselor will revise all applicable Outpatient accounts when no inpatient accounts exist.
 - Inpatient Financial Counselor will revise all applicable inpatient accounts, submit Change of Billing to Patient Accounting Dept. and forward to Ward 24 to revise Outpatient accounts.
- c) The Financial Counselor enters activity code ABAP (AB774 Approved) in Invision account to differentiate patients approved for Charity Care and Discount Payment. The Financial Counselor will input the date of the application in INVISION.
- d) The Financial Counselor forwards a copy of the application to the Business Office for appropriate adjustments on inpatient accounts.

2. Denial

- a) The Financial counselor revises the accounts denied for the discount by entering activity code ABDN (AB774 Denied) that identifies the application and denial for Charity Care and Discount payment. The Financial Counselor will input the date of the application in INVISION.
- b) Denied applications will be filed in the eligibility department for file record and reference.

3. Account Pending Insurance Payment

- a) The Financial Counselor enters activity code ABIN (AB774 with Insurance) in Invision account and manually enters date of application. This will allow account to continue its usual process for resolution. Eventually if account has Patient Liability, then note on account (ABIN) will let Billing/Patient Inquiry know that patient qualified for AB774.

K. Eligibility Appeals Process

1. Patient may appeal the denial and must submit written request within 15 business days of receiving their denial determination to the Eligibility Manager. The patient must submit the following items:

- Copy of complete application
- Statement requesting reason for review

Send to:
San Francisco General Hospital
1001 Potrero Ave, Ward 15
San Francisco, CA 94110
Attention: Jenine Smith, Eligibility Manager

2. 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 Supervisors of the Emergency Department Registration, Outpatient Registration, Admissions Office, and Billing Office will ensure the following:

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

M. The Business office keeps accounts for balance resolution.

Approved AB774 Patients with Liability:

- a. Patients who qualify for AB774 Charity Care or Discount Payment program with a payment liability will receive a series of letters that are thirty days apart, indicating the amount owed after program discount has been applied.
- b. Patients a payment liability have the option to arrange an installment payment plan. The Business Office will coordinate payment plans that do not exceed three (3) months from conversion to the Charity Care or Discount Payment program. Payment plans exceeding three (3) months will be forwarded to the City and County of San Francisco's Bureau of Delinquent Revenue (BDR) (Collection Agency) to coordinate with the patient on behalf of the hospital.
- c. BDR will attempt to reach a reasonable payment plan agreement with the patient. If BDR and the patient are unable to reach a payment plan agreement, BDR will calculate monthly payments not exceeding 10% of the patient's family income excluding essential living expenses deductions.
 - i. BDR will accept verification of the patient's essential living expenses to deduct from the family income and calculate a reasonable payment plan consisting of monthly payments not exceeding 10% of the patient's family income.
 - ii. If patient is unable to provide verification, BDR will use the specified formula of deducting 60% for essential living expenses from patient's gross household income and then calculate 10% of the remaining income to determine a reasonable monthly payment amount.
 - iii. The minimum monthly payment must not be less than \$10.00. Therefore, when the calculated monthly payment is less than \$10.00, the monthly payment will be \$10.00.
 - iv. With discretion and under thorough review, BDR may accept self-attestation of family income and essential living expenses.
- d. If a patient does not respond to the Charity Care or Discount Payment program notice of their payment liability, , or does not adhere to their established three month payment plan agreement with the Business Office, the patient will be referred to the Bureau of Delinquent Revenue for further collections.

V. Bureau of Delinquent Revenue (BDR) Collection Procedures:

- i. Upon assignment for collection BDR will screen the new placement account, and if applicable, will put the account on a collection hold until the account has aged to 150 days of delinquency. During this hold period no collection work is performed on the account.

- ii. Once the account ages to 150 days from the date of service BDR will assign the account for collection and will send delinquent notices to the patients (one notice at 5 days delinquent and the final notice at 30 days delinquency) to initiate contact. In addition to the notices collection calls are also made when possible. If required skip tracing is also performed to locate the best address and/or contact phone number for the patient. Once contact is made BDR will attempt to collect the full amount of the delinquent bill(s), or prepare negotiations for other payment arrangements if the patient is unable to pay the full amount.
- iii. If the patient states that he/she is unable to pay the full amount BDR will probe to determine why and will begin assessing the patient's ability to pay. This evaluation will include but is not limited to a review of the patient's income, tax records, bank statements, 3rd party coverage if applicable (discounts are revoked if 3rd party coverage is found), real property and commercial assets, liabilities, and essential living expenses. If the patient is not compliant in providing the necessary information or it is determined that the patient has the ability to pay, is not eligible for AB774, and does not require a payment plan as prescribed in section 5 of the PP (titled Approved AB774 Patients with Liability sub sections C i-iii) then BDR will continue to pursue the collection of the full balance. If necessary BDR will implement escalated collection efforts to remedy the delinquent balance, which may include legal action and/or assignment to a collection agency.
- iv. Patients who have been determined to have a financial hardship will be screened for AB774 and will be given the applicable charity adjustment or discount according to the AB774 PP. Once the account balances have been adjusted the patient is sent a notice to advise of the new balance due and given an opportunity to pay the adjusted amount in full. Collection efforts will resume to obtain full payment or until agreeable payment arrangement can be reached to resolve the balance.
- v. For patients who are eligible for AB774 that fall under IPC's 841, 843, or 844 and are unable to pay the \$5,000 - \$15,000 adjusted/discounted amount in full, and unable to meet the initial payment options offered by BDR, will then be offered the SB1276 payment plan. The one-time \$50 installment payment plan fee will not be added to the account, the patient is provided the general payment plan agreement to sign, and the payment is then set-up according to the SB1276 Average Living Expense Payment Plan Grid. All SB1276 payment plan accounts will be tracked in the BDR collection system.
- vi. Patients who have been qualified for the AB774 charity or discount and/or the SB1276 payment plan and default on the payment plan will be pursued in the normal course of the BDR collection process to collect the balance due.

VI. Patient Statements

Patient statements will include referral information to the following local consumer assistance center housed at legal services offices:

- Health Consumer Alliance
(888) 804-3536
- The Health Consumer Center/Bay Area Legal Aid
1735 Telegraph Avenue
Oakland, CA 94612
(855) 693-7285.