EL CAMINO HOSPITAL
ADMINISTRATIVE POLICIES AND PROCEDURES

35.00 CHARITY CARE/ FINANCIAL NEED DISCOUNT POLICY

A. Coverage

This policy applies to patients who are self-pay or have high medical costs and have a family income that does not exceed 400% of the federal poverty level (FPL). Patients who are covered are those who do not qualify for state and federal sponsored programs, have high medical costs, are uninsured or insured but are unable to pay the full patient liability under their insurance plan. Coverage applies to patients seeking inpatient or outpatient services from El Camino Hospital.

B. Reviewed/Revised: 4/00, 7/03, 6/04, 1/07, 6/07, 4/08, 06/09, 02/11, 12/11

C. References

California Assembly Bill 774, adopted September, 2006

D. Policy Summary

The purpose of this policy is to define the eligibility criteria for charity care and/or financial need discounts for patients who are uninsured or under-insured with high medical costs as well as to identify a process for screening patients and determining the individual's ability to pay. Charity is not considered to be a substitute for personal responsibility. El Camino Hospital is committed to providing charity care or financial need discounts to patients who are uninsured, underinsured, ineligible for government programs, and are otherwise unable to pay for their medical services. El Camino Hospital provides community benefit services such as RotaCare Clinic and will classify them as charity care. El Camino Hospital strives to ensure that the financial capacity of our patients does not prevent them from seeking or receiving medical care at El Camino Hospital.

Patients are expected to cooperate fully with El Camino Hospital's procedures for obtaining financial need discounts and to contribute to the cost of their care based on their ability to pay. Charity care and financial need discounts will be available on a sliding scale, in accordance with financial need as determined by: the information supplied on the charity care application, FPL, and/or applicable state and federal regulations.

Patients will be treated fairly, with dignity, courtesy, compassion, and respect. All patient information is kept confidential, and the handling of personal health

information is protected in accordance with federal and state privacy laws.

For patients who qualify for charity care or financial assistance discounts and who are cooperating in good faith to resolve their hospital bills El Camino Hospital will not impose wage garnishments or liens on primary residences will not credit report and will cease all collection efforts.

Charity care and discounted payments are also available for qualified patients from emergency room physicians.

E. Eligibility Criteria

1. Eligibility for Self-Pay Patients

a. A patient who is uninsured and who is at or below 400% of the federal poverty level (FPL) is eligible to apply for charity care.
b. An uninsured, aka self-pay patient, is a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medi-Cal, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital.
c. Federal Poverty Level (FPL) is the poverty guidelines as defined and updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.
d. RotaCare patients have been screened through the RotaCare Clinic and therefore automatically qualify for 100% charity care and are not required to fill out an application.
e. Patients who have been recognized homeless and deceased patients with no estate may be deemed eligible without having to meet the documentation requirements. Under these circumstances, the Director of Patient Financial Services will give approval to waive these requirements.
f. In cases where the patient is non-responsive and/or other sources of information are readily available to perform an individual assessment of financial need, these sources of information can be used to support and/or validate the decision for qualifying a patient for a full or partial charity discount. Under these circumstances, the Director of Patient Financial Services will review each case for financial assistance supported and/or validated by other sources of information to determine whether a patient is qualified for full or partial charity discount.
g. Patients whose income exceeds 400% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on specific circumstances, such as catastrophic illness or medical indigence, at the discretion of the PFS Director or Asst Chief Financial Officer or Chief Financial Officer.

2. Eligibility for Insured Patients

a. A patient who is insured but has "high medical costs" and who is at or below 400% of the federal poverty level ("FPL") is eligible to apply for charity care.
b. Charity care applies to the portion of the bill that is the patient's responsibility, including co-payments and deductibles.
c. Any patient liability that is based on a discounted rate from the hospital's charges as negotiated between the hospital and the insurer is not eligible to be considered for charity care. For example, if a patient has an annual $5,000 deductible, but the patient's insurance plan has negotiated a rate with the hospital so that the deductible amount applies to a rate equal to 80% of the hospital's charges, then the patient is not eligible for charity care.
d. "A patient with high medical costs" is defined as a person whose family income does not exceed 400% of the federal poverty level if that individual does not receive a discounted rate from the hospital as a result of his or her third-party coverage. Additionally, "high medical costs" means the following:
    1) 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.
    2) Annual out-of-pocket medical 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.
e. The insured patient's financial responsibility (e.g., co-payments and deductibles) should be limited to the amount by which the maximum government program rate for the services exceeds the payment received from the third party payer. If the insurance company's payment exceeds the payment limitation, no amount may be collected from the patient. For example, if services provided results in an insurance company expected payment of $2,500 but the Medicare reimbursement rate is $2,000, then the patient has no obligation to pay outstanding balance for services. However, if Medicare reimbursement is $3,000, then the patient is obligated to pay $500 to the hospital for services.
f. A patient's family is defined as a patient's spouse, domestic partner, and dependent children under 21 years of age. For patients under 18 years of age, their parent(s), caretaker relatives and other children under 21 years of age of the parent or caretaker relative.
g. If a patient has been assigned Medi-Cal share of cost, the share of cost amount will be eligible for charity care.
h. Patients whose income exceeds 400% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on specific circumstances, such as catastrophic illness or medical indigence, at the discretion of the PFS Director or Asst Chief Financial Officer or Chief Financial Officer.

F. Policy and Procedure

1. *Qualification Criteria*

a. In order to qualify, the patient must meet eligibility criteria in either section E.1 or E.2 of this policy.

b. In addition to satisfying criteria under section F.1.a of this policy, all of the following conditions must apply:

1) Patient must apply for Medi-Cal coverage, as requested. If denied, then the patient must provide El Camino Hospital with the written denial.

2) Patient completes a Charity Care application (Appendix A) and returns it to Patient Accounts within two weeks.

c. A hospital may not exclude any financially qualified individual once he or she is accepted as a patient, and may not exclude any services furnished to a financially qualified patient.

2. Application Review Process

a. Upon registration, all self-pay patients will be given a Charity Care Application. Otherwise, Charity Care applications will be available upon request in Patient Registration and Patient Accounts offices.

b. The patient will be allowed two (2) weeks to complete the Charity Care application.

c. All inpatient applicants will be screened to determine linkage with Medi-Cal, Medicare, Health Family Program, California Children Services, or any other payer source.

d. The completed Charity Care application is directed to Patient Accounts.

e. Patient Accounts will place the account(s) the patient is applying for charity care on Account Follow-Up Hold, and determine whether the application is complete and that the required information is attached.

f. Patient Accounts will review documents within one business day to confirm that information provided by patient is substantiated. Patient Accounts must validate proof of income through pay stubs or income tax returns.

g. The approval process will include the following:

1) Determination of whether the patient is eligible as a self-pay patient or insured patient
2) If patient is applying as a self-pay:
    a. Calculate FPL percentage based on family size.

b. Obtain Medi-Cal denial.
c. Determine discounted percentage based on FPL percentage (see the Discount Level Table in Appendix B).

3) If patient is applying as an insured patient:
   a. Determine whether the patient liability is based on a discounted rate from the hospital's charges as negotiated between the hospital and the insurer per section E.2.c of this policy.
   b. Calculate FPL percentage based on family size.
   c. If applicant is below 400% FPL, then determine whether patient has "high medical costs" based on section E.2.d of this policy.
   d. If high medical cost is greater than 10% of annual family income, then determine discount, if any, based on section E.2.e of this policy.
4) The reviewed application is sent to Patient Accounts Director for review and approval level determination.

3. Application approval level determination

a. Approval status will be granted based on the qualification criteria, the information supplied on the application, the required documentation, and the income schedule set by El Camino Hospital.

1) Charity Care: Patient is eligible for 100% charity care or free care.

2) Financial Need Discount: Patient is eligible for at a minimum the greater of Medicare, Healthy Families, Medi-Cal, Champus, or CCS payment rate. The discount level increases based on a sliding scale as set by the Discount Level Table in Appendix B for self-pay patients. Please refer to Appendix C for discounts applicable to insured patients.

3) Application Denied: No financial assistance is granted under this policy. However, if patient is self-pay, patient may be eligible for a 75% discount through ECH's Patient Payment Policy.

4. *Procedure for Approved Applications*

a. Once the application is approved, Patient Accounts will adjust the approved discounted amount in HBOC, leaving the patient with a zero balance or discounted amount due.

b. Patient Accounts will send the patient an acceptance letter (Appendix D).

c. Patient Accounts will remove account(s) from Account Follow-Up Hold.

d. Patient Accounts will add a free form note in HBOC, under account inquiry, type "Approved Charity Care." In the body of the note, state the specifics of the approval. If applicable, set up a payment plan in HBOC which will generate a payment plan agreement letter.

e. Patient Accounts will screen print the flashcard screen, attach to Charity Care application and place in yellow file folder marked "Approved Charity Care."

f. Approvals are effective on the date of management's approval and remain valid for a period of one year, unless there is a change in the patient's financial status, at which point a new application must be completed.

g. Patients who are receiving long term care such as dialysis or sub-acute services will be required to complete a Charity Care application annually.

5. Procedure for Denied Applications

a. If denied, Patient Accounts will send the patient a denial letter, stating the reason(s) for the denial and who to contact to dispute. (Appendix E).

b. Patient Accounts will add a free form note in HBOC, under account inquiry, type read "Denied Charity Care" in the body of the note, and state the specifics of the denial.

c. Patient Accounts will then remove account(s) from Account Follow-Up hold and resume normal collection activity on the account(s) per Patient Accounts debt collection policy.

d. Screen print the flash card screen and attach to Charity Care application and place in red file marked "Denied Charity Care".

6. *Procedure for Appeals to Denied Applications*

a. Upon notification of an appeal, Patient Accounts will add a free form note in HBOC, under account inquiry; type read "Denied Charity Care pending appeal" in the body of the note.

b. The application being appealed will be reviewed by the Director of Patient Accounts, Assistant CFO, or CFO as appropriate.

c. If denial is reversed, then the reviewer will send the patient an appeal acceptance letter, stating the reason(s) for the acceptance. Patient Accounts will update the account per procedure in section F.4 of this policy.

d. If denial is upheld, then the reviewer will send the patient an appeal denied letter, stating the reason(s) for the denial. Patient Accounts will update the account per procedure in section F.5 of this policy.

7. Debt Collections for Eligible Patients

a. If payment has not been received in full by agreed upon timeline, Patient Accounts will enforce its debt collection policy.

b. The hospital shall not allow an account to have adverse information reported to a credit reporting agency or commence civil action against the patient for non payment at any time prior to 150 days after initial billing.

c. If a patient has a pending appeal for coverage of services, the hospital shall not allow an account to have adverse information reported to a credit reporting agency or commence civil action against the patient for non payment at any time prior to 150 days after the patient's appeal is completed.

8. Reimbursement to Patients

a. Any amount collected from a patient in excess of the amount due under this policy will be reimbursed to the patient at an annual interest rate of 7 percent.

9. Public Notices of Charity Care Policy

a. Public notices are posted concerning availability of charity care and financial need discounts by the following means:
   i. Notices are posted in visible locations where there are high volumes of inpatient and/or outpatient registrations, the emergency department, patient accounts, patient registration, and hospital outpatient service settings.
   ii. These posted notices explain that El Camino Hospital has a variety of options available including financial assistance to patients who are uninsured or have high medical costs.
   iii. The notices include a contact phone number the patient can call to obtain more information about the policy and about how to apply for assistance.

10. Reporting and Monitoring

a. The transaction codes used for accounting for charity care and their mapping to the General Ledger must be reviewed periodically to ensure accuracy by internal audit.
b. All charity care write-offs are reviewed on a periodic basis by internal audit.
c. An internal audit will be conducted annually to sample cases and assure procedures have been followed for the appropriate application of charity care.

Appendix A –Charity Care Application
Page One of Three

El Camino Hospital
Charity Care Application

Account Number(s)_____

Patient's Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

County _____ Marital Status _____

SSN # _____ Phone # _____

Name of Spouse _____ No. of Dependents_____
Ages_____

Name of Parent(s)/Guardian(s) Employer Name/Address/Telephone

_____ _____

Annual family income: $ _____ _____

(please attach copies of most recent pay stubs or income tax returns) _____

Have you applied for Medi-Cal?	☐ Yes	☐ No
Are you under 21 years of age?	☐ Yes	☐ No
Are you 65 years of age or older?	☐ Yes	☐ No
Are you legally blind?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Are you unable to work because of a physical or mental illness or disability that is expected to last longer than one year?	☐ Yes	☐ No
Do you have a minor child under 21 years of age in your home?	☐ Yes	☐ No
Do you have Medicare?	☐ Yes	☐ No
Do you have Health Insurance?	☐ Yes	☐ No
If yes, please list _____		
Do you live in a nursing home?	☐ Yes	☐ No
Are you a veteran or a dependent of a veteran?	☐ Yes	☐ No
Are you being treated as a victim of a crime incident?	☐ Yes	☐ No
Are you being treated for a Workers Comp injury?	☐ Yes	☐ No

List all sources of assistance available to the patient

Medicare	☐ Yes	☐ No
Medi-Cal	☐ Yes	☐ No
Commercial Insurance Coverage	☐ Yes	☐ No
Out-Of-Country Insurance, explain below coverage limitations	☐ Yes	☐ No
Community Services, list source below	☐ Yes	☐ No
Family, list source below	☐ Yes	☐ No

Comments: _____

_____

Appendix A –Charity Care Application
Page Two of Three

Patient's Name_____ Date _____

Requesting Charity Care For: (Check all that apply)

- ☐ Total charges on patient bill(s) $_____
- ☐ Co-insurance/Co-payment $_____
- ☐ Deductible(s) $_____
- ☐ Other patient liabilities (non-covered items) $_____
- ☐ Medi-Cal Share of Cost $_____

If your insurance company is paying a portion of your bill, please complete the following and attach copies of the supporting receipts, invoices, bills, or other documentation.

Out-of-pocket expenses incurred by you at El Camino Hospital within 12 month period of application:*
$_____ *Out-of-pocket expenses are all patient bill balances, co-insurance, co-payment, or deductibles incurred at El Camino Hospital by the patient.

*Out-of-pocket medical expenses** paid by you or your family within 12 month period of application:* $_____ **Out-of-pocket medical expenses are any medical expenses paid by the patient or the patient's family, including expenses paid for physician services, hospital services, drugs, and any other medical services.

A patient's family is defined as a patient's spouse, domestic partner, and dependent children under 21 years of age. For patients under 18 years of age, their parent(s), caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

I attest that the financial information I have provided is complete and accurate and I agree that El Camino Hospital may verify this information. I agree to notify Patient Accounts of any changes in my financial circumstances and to provide upon request, insurance eligibility status.

I agree that El Camino Hospital may disclose the information contained on this application to any third party who may help fulfill my request for charity care or financial need discounts.

Patient's Signature_____ ***Date*** _____

Representative for Patient Signature _____ *Relationship* _____

Appendix A –Charity Care Application – Self-Pay Patient
Page Three of Three

Federal Poverty Levels for the 48 contiguous states and the District of Columbia - 2011		
Size of Family:	**Federal Poverty Level:**	**400%**
1	$10,890	$ 43,560
2	$14,710	$ 58,840
3	$18,530	$ 74,120
4	$22,350	$ 89,400
5	$26,170	$104,680
6	$29,990	$119,960
7	$33,810	$135,240
8	$37,630	$150,520

Approval Categories	**Benefit Amount**
Charity Care	
If patient is self-pay, net annual income is less than 300% of Federal Poverty Level	100% charity care or free care.
If patient is insured, net annual income is less than 400% of federal poverty level AND annual out-of-pocket expense exceeds 10% of total annual income of patient or patient's family AND insurance company payment exceeds maximum government rate	
Financial Need Discount	
If patient is self-pay, net annual income is between 301% and 400% Federal Poverty Level	If patient is self-pay, no less than 85% financial need discount for inpatient services and 90% financial need discount for outpatient services.
If patient is insured, net annual income is less than 400% of federal poverty level AND annual out-of-pocket expense exceeds 10% of total annual income of patient or patient's family AND maximum government rate exceeds insurance company payment	If patient is insured, patient liability is reduced to the difference between maximum government rate and insurance company payment. For balances $12,000 or lower, ECH is willing to accept up to twelve monthly installment payments without interest. Any balances greater than $12,000 ECH will send to an external collection service who will provide long term payment plans without interest.

Application Denied Patient does not meet criteria for charity care or financial need discounts under this policy.	No financial assistance is granted under this policy. If patient is a self-pay patient, patient may be eligible for a 75% discount through ECH's Patient Payment Policy. For balances of $5,000 or lower, ECH is willing to accept up to four monthly installment payments without interest. Any balances greater than $5,000 ECH will send to an external collection service who can provide long term payment plans without interest.

Appendix B –Charity Care Application Worksheet for Self-Pay Patient

Page One

FPL (A): _____

Annual Family Income (B): _____

Family Income Percent of FPL (B/A): _____

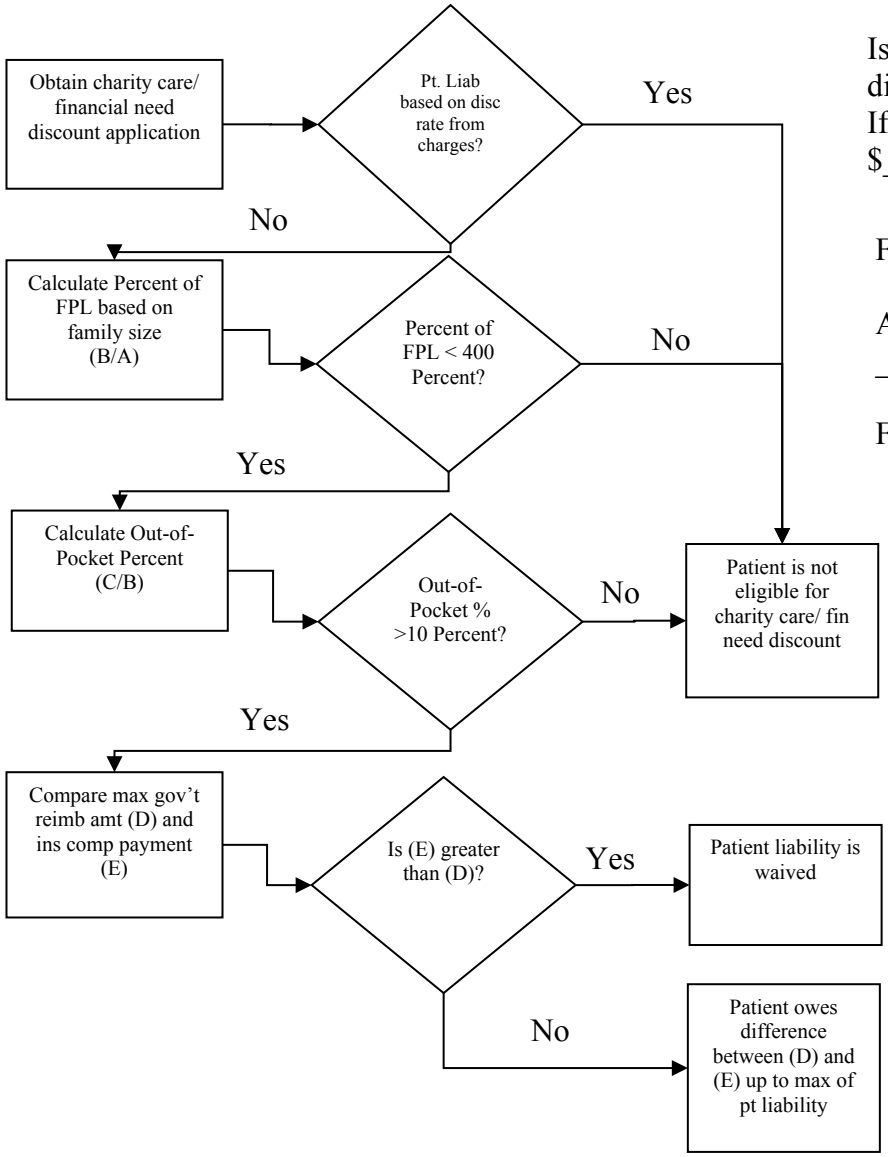
Federal Poverty Levels for the 48 contiguous states and the District of Columbia - 2011		
Size of Family:	**Federal Poverty Level:**	**400%**
1	$10,890	$ 43,560
2	$14,710	$ 58,840
3	$18,530	$ 74,120
4	$22,350	$ 89,400
5	$26,170	$104,680
6	$29,990	$119,960
7	$33,810	$135,240
8	$37,630	$150,520

Discount Level Table

% FPL	Inpatient Services Discount	Outpatient Services Discount
400% - 351%	85%	90%
350% - 301%	92%	95%
<300%	100%	100%

See attached spreadsheet summary for discount details

Charity Care Policy
Appendix C –Charity Care Application Worksheet for Insured Patient
Page One



Is patient liability based on discount rate from charges? Y/N
If No, then indicate amt:
$_____

FPL: _____(A)

Annual Family Income:
_____(B)

FPL Percent: _____(B/A)

Annl Out-of-Pocket Expense
_____(C)

O of P Percent of Income:
_____(C/B)

Max gov't reimburse. amt
_____(D)

Ins. payment
_____(E)

Total approved discount amount:
$_____

Approvals:

_____

Director, Patient Financial Services
(Up to $25,000)

_____

Chief Financial Officer
(Up to $250,000)

_____

Chief Executive Officer
(Over $250,000)

Approved: 06/07

Financial Assistance Policy

Appendix D –Approved Charity Care Letter

2500 Grant Road
Mountain View, CA 94040-4378
Phone: 650-940-7000
www.elcaminohospital.org

Date

Patient's Name
Address
City, State ZIP

RE: Financial Assistance Application Approval Notification

Patient Name:
Acct #
Service Dates
Total Charges:

Dear *Patient*:

This letter is to confirm that we have processed your application and determined that you are approved for financial assistance.

You are relieved from financial responsibility for the facility services provided by El Camino Hospital on the above-mentioned account(s) **effective from through .**

If your financial or insurance situation improves, this could affect your future eligibility for financial assistance. It is your responsibility to let us know what has changed if you re-apply for financial assistance.

The financial assistance granted here applies only to hospital services and does not relieve you from financial responsibility for any professional fees of your physician, surgeon, anesthesiology, pathologist, assistants or private duty nurses.

In the future, if your financial circumstances change or if you have any questions or concerns regarding your account(s), please contact our Patient Accounts office at 650-940-7220. You may also contact me directly at 650-988-7933.

Sincerely,

Regina Hernandez
Manager, Specialty & Support Teams

2500 Grant Road
Mountain View, CA 94040-4378
Phone: 650-940-7000
www.elcaminohospital.org

Date

Patient'sName
Address
City, State ZIP

RE: Financial Assistance Application

Patient Name:
Acct #:
Service Date(s):
Total Charges:

Dear *Patient*:

El Camino Hospital has reviewed your request for financial assistance for the above account. We determined you do not meet the criteria for the charity care financial need discount program for the following reason:

- *(Denial Reason)*

As an uninsured patient you are eligible for a 75% discount. Please contact our Customer Service Department at 650-940-7220 to discuss the 75% discount we offer and to set up a suitable payment plan.

If you disagree with this decision and would like to dispute the denial for financial assistance, please contact the Director of Patient Financial Services at 650-988-7853.

Sincerely,

Regina Hernandez
Manager, Specialty & Support Teams