Policy: It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG), Laguna Honda Hospital and the Community Oriented Primary Care Clinics of the San Francisco Health Network to offer a Charity Care and Discount Payment Program consistent with the provisions of Assembly Bill No. 774 (AB774).

The programs are offered to patients as a last resort when all other government assistance programs have been exhausted and the patient requests financial assistance to pay their hospital bill. This Policy applies to services that do not qualify for other discount packages or 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 with dates of service within 12 months prior to date of application will be considered. Accounts with dates of services exceeding 12 months prior to date of application are subject to department approval.

Purpose: This policy and procedure defines the program criteria and requirements of the Charity Care, Discount Payment and Catastrophic High Medical Expense programs, and describes the process for determining program eligibility. The policy and procedure also outline the process for providing a reasonable payment plan to self-pay patients in accordance with SB1276. Patients who apply for one of these programs and are determined to be ineligible may appeal the determination. The steps for timely notification to the patient and to the Business Office are also described.

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.

Background and History:

Effective January 1, 2007 for ZSFG patients, and September 17, 2007 for COPC patients, 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.

Effective November 1, 2010, the Catastrophic High Medical Expense Program is available to assist uninsured or underinsured patient’s 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.

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.
Effective XX, 2019 this policy will be amended to (1) increase the Charity Care Program qualifying income to 500% FPL, (2) eliminate the Discount Payment Program qualifying income to include all FPL levels, (3) eliminate any high medical cost qualifying criteria and (4) terminate the Catastrophic High Medical Expense program.

Definitions and Program Criteria:

A. Charity Care and Discount Payment Program Application Requirements:

1. Submission of application and required verification per program criteria.
2. Full cooperation with pursuit of all potential third-party liability and provide all required verification of other coverage within 30 days from receipt of application.
3. Full cooperation with applying for government programs for which potentially eligibility has been determined. Patients who do not cooperate will not be eligible.
4. Services that are part of a package program and provided at a discounted rate are not eligible for the Charity Care or the Discount Program.

B. Definition of and Requirements for Charity Care:

Charity Care will be offered to uninsured and underinsured patients with income levels not exceeding 500% of the FPL, and qualified assets must not exceed $250.00 at the time of service in accordance with AB774.

(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.)

1. An application must be completed and required income verifications provided 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.
      i. Healthy San Francisco enrolled applicant may replace item (a) requirement with Proof of Income submitted to Healthy San Francisco.
      ii. 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.
      iii. 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.
      iv. Patients with ZSFG admission who cooperate with applying for Medi-Cal, may substitute Medi-Cal application and verification for Charity Care Program application.
   b. Last 3 months of bank or brokerage account statements from date of Charity application.
      i. 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.).

2. **FPL is determined and used on a four-tiered system to determine the qualifying Charity Care discount. Income is verified at levels 0% - 138%, 139% to 200%, 201% to 350%, and 351-500% FPL will receive varying Charity Care discounts.**

3. Applications provided without asset information will be considered for the Discount Payment Program only.

### C. Definition of and Requirements for Discount Program:

1. Discount Payment program will be offered to uninsured and underinsured patients at any federal poverty level and who do not qualify for Charity Care in accordance with AB774. Federal poverty level will be assessed to determine the qualifying discount.

2. Patients who receive a discounted rate from the hospital as a result of full cooperation with third-party liability coverage.

3. 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.

4. 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.

5. 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.
   
   b. Healthy San Francisco enrolled applicant may replace item (a) requirement with Proof of Income submitted to Healthy San Francisco.

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

Refer to the *Charity Care and Discount Payment Charts Policy and Procedure* for discounts and patient liabilities per program when eligibility is determined.

### Procedure:

Patients are interviewed by Eligibility for 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, including:

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. Workers Compensation injuries at work
B. Refer Patients for County and State Programs 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 and/or provided application assistance as appropriate, such as the Medi-Cal Program, the San Francisco County’s Sliding Scale program or other governmental program. This application will be provided prior to discharge if the patient has been admitted or made available to patients receiving emergency or outpatient care.

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

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.

The Business Office sends out notices with patient bills as required by AB 774 and includes information about 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. Healthcare Program Application and Enrollment Assistance

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 Counselor enrollment and application assistance includes the following programs and insurance:
1. Medi-Cal
2. Hospital Presumptive Eligibility Medi-Cal 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 Program

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

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

F. Required Verifications of Household Income and Assets
   1. Income verification (one of the following):

      a. Most recent 3 months of pay stubs from date of application or complete most recent year income tax return. Other forms of income verification provided may be evaluated to determine if acceptable.

      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 verification (all that apply)
Assets are required for the Charity Care program. If assets are not provided, patient may only be evaluated for Discount Payment program.
   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. Patients with ZSFG admission, who cooperate with applying for Medi-Cal, may replace asset verification with Medi-Cal verification.

G. Third party coverage verification (if applicable)
   1. Third party insurance information
   2. Auto insurance or liability information
   3. Denial notices for government programs
   4. Settlement results of lawsuits

H. Notification of Eligibility Determination
   1. Verifications must be provided within 30 days of application submission or will be denied.
   2. When a complete application is submitted, the Financial Counselor will first evaluate for Charity Care, and if determined ineligible, will then evaluate for the Discount Payment program.

   1. The Financial Counselor will make a determination of program eligibility and submit to the supervisor for review.
   2. Following supervisor review and eligibility confirmation, the Financial Counselor notifies the patient and the Business Office.

I. Notification to Patient
   1. Approval
      The Financial Counselor will complete the insurance plan 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. Approved Accounts Pending Insurance Payment or Third-Party Liability

   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, the note on account (ABIN) will let Billing/Patient Inquiry know that patient qualified for AB774.

3. 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.

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.

**II. 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 and are unable to pay 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.

III. 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.