CHINESE HOSPITAL
845 JACKSON STREET, SAN FRANCISCO, CA 94133

POLICY SUMMARY/INTENT

The purpose of this policy is to ensure compliance with Assembly Bill 774, which was signed into law in California and is effective January 1, 2007, Senate Bill 350 which was signed into law in California and is effective January 1, 2008, Assembly Bill 1503 which was signed into law in California and is effective 1/1/2011, and Senate Bill 1276 which was signed into law in California and is effective 1/1/2015.

The mandates contained in AB 774, SB 350, AB 1503, and SB 1276 must be performed by the Hospital as a condition of licensure and will be enforced by the California State Department of Health Services. 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.

RESPONSIBILITY

It is the responsibility of the Hospital Revenue Cycle Manager, with approval from the Hospital Chief Financial Officer, to develop procedures to implement this Policy.

POLICY: COMPLIANCE - KEY ELEMENTS

It is the policy of Chinese Hospital (the “Hospital”) to provide emergency and other medically necessary care to all patients regardless of ability to pay. The Hospital is not required to provide non-emergency health care; however, if the Hospital chooses to accept patients for non-emergency care, those patients may be eligible for a charity discount as required by AB774.

Uninsured patients or patients with high medical costs who indicate an inability to pay must be screened for potential charity assistance. Screening for charity assistance will occur only after all other potential resources have been exhausted. The Hospital is required to obtain information about whether the patient may be eligible for the California Health Benefit Exchange and to include in the information provided to a patient that has not shown proof of third party coverage a statement that the consumer may be eligible for coverage through the California Health Benefit Exchange or other state or county-funded health coverage programs. The screening process will optimally occur at the time of service but may occur anytime during the collection process including post assignment to an outside collection agency.

To be financially qualified under California charity laws, a patient must be self-pay or have high medical costs and not have family income in excess of 350% of the Federal Poverty Level. A self-pay patient is defined as a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare or Medicaid, 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. Self-pay patients may include charity patients. High medical costs is defined as any of the following:

1. Annual out-of-pocket costs incurred by the individual at the Hospital that exceed 10% of the patient's family income in the prior 12 months.

2. Annual out-of-pocket expenses that exceed 10% 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.
3. A lower level determined by the Hospital in accordance with the Hospital's charity policy.

AB 1503 amended AB 774 and effective 1/1/11 requires emergency room physicians that provide emergency medical services in a general acute care hospital to develop charity care and discounted payment policies to limit expected payment from eligible patients that are uninsured or have high medical costs who are at or below 350% of the federal poverty level. Patients who are uninsured or have high medical costs and income at or below 350% of the federal poverty level and receive a bill from an emergency room physician should contact that physician's office and request charity assistance. SB 1276 put new requirements upon emergency room physicians similar to those requirements placed upon The Hospital. The emergency room physician fees will be included in the FAP for Chinese Hospital.

The Hospital may develop abbreviated screening procedures for those service areas where charges are low such as clinics, rural health clinics, emergency departments and outpatient ancillary areas (defined below). At a minimum, the Hospital will document family size and gross family income and a credit report will be secured. In those service areas where charges are higher such as inpatient and outpatient surgery, the Hospital will complete a full financial screening and require income verification from the patient.

DURATION

Approved charity discounts are considered valid for all existing accounts and for an additional 90 days after approval.

CATASTROPHIC CHARITY DISCOUNTS

Based upon the patients' complete financial situation, when the patient liability amount exceeds 50% of the total annual family income, amounts greater than 50% of the income may be written off to a charity discount.

CLASSIFICATION AS STATUTORY OR NON STATUTORY

Charity discounts will be classified into two categories: statutory and non-statutory.

STATUTORY CHARITY DISCOUNTS

Statutory charity discounts will be defined by Hospital participation in various federal, state, and/or county indigent care programs. Criteria must comply with governmental guidelines and/or state or county regulations.

Each patient who appears eligible for a statutory charity discount determination and who requests such determination must complete a Confidential Financial Statement (exhibit A in English and Chinese). Additionally, he/she must provide supporting documentation to the financial counselor as required to verify his/her financial condition. Statutory charity discounts will generally be identified at the time of admission or while the patient is in-house by the Hospital financial counselor, however, it may also be identified after discharge or whenever a patient declares an inability to pay.

NON-STATUTORY CHARITY DISCOUNT

A Non-Statutory Charity discount is defined as a charity discount for patients known to meet the general discount criteria. The determination of non-statutory discounts will be made at admission or while the patient is in-house; however, this determination could also be made after discharge or whenever the patient declares an inability to pay.

Unless the patient qualifies for the abbreviated screening procedure, every effort will be made to secure a signed application, but this may not be possible in all cases. Patients stating that they are homeless and without income, at the discretion of the Revenue Cycle Manager do not need to complete a Confidential Financial Statement. Instead, charity discount determinations may be made by the financial counselor's completion of the eligibility worksheet. Non-statutory charity discounts should be used for homeless patients that have no income or documentation to report. Additionally, charity discounts will be used to write off accounts of patients who are deceased and research has shown that there is no estate or other responsible relative and no possibility of further collection. Finally, charity discounts will be used to write off accounts of patients where the court has entered a final bankruptcy judgment and there is no potential for further collection.

ELIGIBILITY FOR OTHER GOVERNMENT PROGRAMS

The Hospital shall make all reasonable efforts to obtain from the patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered to a patient. Including, but not limited to, any of the following:

1. Private health insurance, including coverage offered through the California Health Benefit Exchange;
2. Medicare; and/or
3. The Medi-Cal program, the Healthy Families Program, the California Children’s Services program, or other state-funded programs designed to provide health coverage.

If the Hospital bills a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, as a part of that billing, the Hospital shall provide the patient with a clear and conspicuous notice that includes all of the following:

1. A statement of charges for services rendered by the Hospital.
2. A request that the patient inform the Hospital if the patient has health insurance coverage, Medicare, Healthy Families Program, Medi-Cal, or other coverage.
3. A statement that, if the consumer does not have health insurance coverage, they may be eligible for Medicare, Healthy Families Program, Medi-Cal, coverage offered through the California Health Benefit Exchange, California Children's Services Program, other state or county-funded health coverage, or charity care.
4. A Statement indicating how a patient may obtain applications for the Medi-Cal program and the Healthy Families Program, coverage offered through the California Health Benefit Exchange, or other state or county-funded health coverage programs and that the Hospital will provide these applications. The Hospital shall also provide patients with a referral to a local consumer assistance center housed at legal services offices. If the patient does not indicate third party coverage or requests a discounted price or charity care, then the Hospital shall provide an application for the Medi-Cal program, the Healthy Families Program, or other state or county funded health coverage programs. This application shall be provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care.

5. Information regarding the financially qualified patient and charity care application including the following:
    a. A statement that indicates that if the patient lacks, or has inadequate, insurance, and meets certain low and moderate-income requirements, the patient may qualify for discounted payment or charity care.
    b. The name and telephone number of a Hospital employee or office from whom or which the patient may obtain information about the Hospital's discount payment and charity care policies, and how to apply for that assistance.
    c. If a patient applies, or has a pending application, for another health coverage program at the same time that he or she applies for a Hospital charity care or discount payment program, neither application shall preclude eligibility for the other program.

MEDICAID DENIALS

A patient who is qualified for Medicaid is also presumed to qualify for a full charity discount. Any charges for days or services written off (excluding billing timeliness, medical records, missing invoices, or eligibility issues) as a result of a Medicaid denial (such as TAR denial) should be written off to non-statutory charity. The total amount of the charges not covered must be written to charity including the Medicaid contractual amount and the expected payment amount. There should be nothing written off to Medicaid contractual for the non-covered charges.

RESTRICTED MEDICAID COVERAGE

Some Medicaid plans offer coverage for a limited or restricted list of services. If a patient is eligible for Medicaid, any charges for days or services not covered should be written off to non-statutory charity and does not require a completed Confidential Financial Statement. This does not include any Share of Cost (SOC) amounts, as SOC's are determined by the state to be an amount that the patient must pay before the patient is eligible for Medicaid.

UNCOOPERATIVE PATIENTS

Uncooperative patients are defined as patients or guarantors who are unwilling to disclose the necessary financial information as requested for Medicaid and/or charity discount determination during the screening process. In these cases, the account will not be processed as charity. The patient will be advised that unless they comply and provide the information, no further consideration will be given for charity discount processing, and standard AIR follow-up will begin.

Non-Compliant patients are defined as not meeting all required documentation for Medicaid/Medi-Cal screening but qualifying for a charity discount. In these cases, the Financial Counselor may process the account for a charity discount, and the account will remain in the charity-pending financial class until the Hospital processes a charity write-off adjustment.

PARTIAL CHARITY CARE

DISCOUNT LEVELS

Amount Generally Billed (AGB) is the maximum amount that may be billed to an individual eligible for financial assistance under this Financial Assistance Policy. The maximum charge to a patient is limited to no more than the AGB percentage multiplied by the hospital's gross charges for the eligible services provided to the patient. Chinese Hospital determined a 30% AGB based on past claims allowed under Medicare and private insurance (the "lookback method"). Patients may obtain additional information regarding Chinese Hospital's AGB percentage and how it was calculated by contacting hospital Finance department 415-677-2485.

The Hospital shall limit expected payment for services it provides to any patient at or below 350 percent of the federal poverty level, as defined in subdivision (b) of Section 124700 of the Health and Safety Code, eligible under its discount payment policy to the amount of payment the Hospital would expect, in good faith, to receive for providing services from Medicare, Medi-Cal, Healthy Families, or any other government-sponsored health program of health benefits in which the Hospital participates, whichever is greater.

If the Hospital chooses to include financial assets as part of the financial screening and charity eligibility determination process it will be restricted in its ability to do so by SB 1276, which requires that the first $10,000 of monetary assets not be counted. Additionally, SB 1276 stipulates that only 50% of monetary assets after the first $10,000 may be counted toward eligibility.

Charity discounts will be granted based upon the following income levels. The Hospital MAY provide greater discounts (lower patient liabilities) to the patient than those established below if approved by the Hospital CFO and documented in the Hospital procedure manual. The Hospital may NOT provide lower discounts (higher liabilities) to qualified patients.

Emergency Services (Including emergency admissions and other medically necessary care):

Income Level:	Patient Liability:
Self-Pay Patients with family Income:	
>200% to 300% of the Federal Poverty Level	50% of Medicare Allowed Amount
>300% to 400% of the Federal Poverty Level	75% of Medicare Allowed Amount
>400% of the Federal Poverty Level	Self-Pay Liability
Patients with Commercial Insurance or non-Contracted Managed Care plans & High Medical Costs (as defined above) and with family Income:	
350% or Less of the Federal Poverty Level	the amount that would be allowed by Medicare for the same service LESS the amount paid by the patient's insurer. If the insurer paid the Medicare allowed amount or greater, patient liability is zero.

All Remaining Services Provided by Hospital (non-emergency related):

Income Level:	Patient Liability:
Self-Pay Patients with family Income:	
200% or less of the Federal Poverty Level	50% of Medicare Allowed Amount
>200% to 350% of the Federal Poverty Level	Medicare Allowed Amount
>350% to 400% of the Federal Poverty Level	75% of Self-Pay Liability
>400% of the Federal Poverty Level	Self-Pay Liability
Patients with Commercial Insurance or non-Contracted Managed Care plans & High Medical Costs (as defined above) and with family income:	
350% or LESS of the Federal Poverty Level	the amount that would be allowed by Medicare for the same service LESS the amount paid by the patient's insurer. If the insurer paid the Medicare allowed amount or greater, patient liability is zero.

Federal Poverty Level (FPL) refers to the statistics produced by the Federal Government each year establishing the income amounts that define poverty levels by state. These statistics are published annually in late January, February or March. The Hospital will always use the most currently published poverty level information available but are NOT required to go back and change a charity determination when a new FPL is issued. FPL's are effective when received by the Hospital and are not service date driven. Patient Financial Services will provide new FPL data to each AH Hospital as soon as it is received.

PAYMENT ARRANGEMENTS:

In cases where the patient or the patient's guarantor has a liability under the charity program and when requested to do so by the patient or guarantor, the Hospital must negotiate a reasonable monthly payment plan with the patient or guarantor. A reasonable payment plan means monthly payments that are not more than ten percent of a patient's family income for a month, excluding deductions for essential living expenses. Essential living expenses means expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses. Any extended payment plan agreed to by the Hospital to assist patients eligible under the Hospital's charity care policy, charity discount payment policy or any other policy adopted by the Hospital to assist low-income patients with no insurance or high medical costs in settling outstanding past due Hospital bills, shall be interest free. Extended payment plans may be declared inoperative when the patient or guarantor fails to make all consecutive payments due during a 90-day period. Before declaring the agreement inoperative, the Hospital or collection agency shall make a reasonable attempt to contact the patient by phone and, to give notice in writing, that the extended payment plan may become inoperative, and of the opportunity to renegotiate the extended payment plan. Before the Hospital can declare the extended payment plan inoperative, they must attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient or their guarantor. Neither the Hospital nor the

collection agency may report adverse information to a credit-reporting bureau before the extended payment plan has been declared inoperative.

If the extended payment plan is declared inoperative due to failed attempts to bring a set payment arrangement current or renegotiations fail, collection efforts will move forward. Accounts will be considered at the first step of collections and will receive a final pre-collection letter giving 30 days to pay the account in full. Should the 30 day time period laps with no resolution, the account will be forwarded to J and L services to begin outside collection services.

FULL CHARITY CARE

All Services Provided by Hospital (Including emergency admissions and other medically necessary care):

Income Level:	Patient Liability:
Self-Pay Patients with family income:	
200% or less of the Federal Poverty Level	Zero

Federal Poverty Level (FPL) refers to the statistics produced by the Federal Government each year establishing the income amounts that define poverty levels by state. These statistics are published annually in late January, February or March. The Hospital will always use the most currently published poverty level information available but are NOT required to go back and change a charity determination when a new FPL is issued. FPL's are effective when received by the Hospital and are not service date driven. Patient Financial Services will provide new FPL data to each AH Hospital as soon as it is received.

If the Hospital chooses to include financial assets as part of the financial screening and charity eligibility determination process it will be restricted in its ability to do so by SB 1276, which requires that the first $10,000 of monetary assets not be counted. Additionally, SB 1276 stipulates that only 50% of monetary assets after the first $10,000 may be counted toward eligibility.

ELIGIBILITY

DOCUMENTATION REQUIREMENTS

Application: Except in those instances where the Hospital has determined that minimum application and documentation requirements apply (as described below), in order to qualify for charity care, a Confidential Financial Statement should be completed. The Confidential Financial Statement allows for the collection of information. Income and documentation requirements are defined below. Pending the completion of such application, the patient must be treated as a pending charity care patient in accordance with the Hospital's policies and the appropriate financial class recorded to reflect this status.

Family Members: Patients will be required to provide the number of family members in their household

- Persons 18 years and older: family members include spouse, domestic partner as defined in section 297 of the Family Code and dependent children under 21 years, whether living at home or not.
- Persons under 18 years: family members include parents, caretaker relatives and other children less than 21 years of age, whether living at home or not.

Income Calculation: Patients will be required to provide their household's yearly gross income.

- Adults: The term "yearly income" on the Confidential Financial Statement means the sum of the total yearly gross income of the patient and patient's spouse.
- Minors: If the patient is a minor, the term "yearly income" on the Confidential Financial Statement means income from the patient, the patient's mother and/or father and/or legal guardian and any other dependents.

INCOME VERIFICATION

Patients will be required to verify the income set forth in the Confidential Financial Statement in accordance with the documentation requirements identified below in cases where documentation is available. Any of the following documents is appropriate for verifying income:

- Income Documentation: Income documentation may include IRS Form W-2, wage and earnings bank statements, or other appropriate indicators of income.
- Participation in a Public Benefit Program: Documentation showing current participation in a public benefit program including Social Security, Workers' Compensation, Unemployment Insurance Benefits, Medicaid, County Indigent Health, AFDC, Food Stamps, WIC, or other similar indigence related programs.

DOCUMENTATION UNAVAILABLE

In cases where the patient is unable to provide documentation verifying income, the following procedures should be followed:

- Obtain Patient's Written Attestation: Have the patient sign the Financial Assistance Application attesting to the accuracy of the income information provided; or
- Obtain Patient's Verbal Attestation: The Financial Counselor who is completing the Confidential Financial Statement may provide written attestation that the patient verbally verified the income calculation. In all cases, at least two attempts must be made and documented to attempt to obtain the appropriate income verification.
- Expired Patients: Expired patients may be deemed to have no income for purposes of the financial calculation. Although no documentation of income is required for expired patients, an asset verification process should be completed to ensure that a charity adjustment is appropriate.

ABBREVIATED APPLICATION PROCESS

The Hospital may establish an abbreviated application and verification process for those services in which they have determined that the typical level of charges are not high such as clinics, emergency departments, and outpatient ancillary areas. In these service areas, the registration department or the financial counselor must at minimum document the family size and the total family gross income in order to determine the level of charity discount if any. In lieu of income documentation, the Hospital must at minimum, pull a credit report to be certain that the patient or the patient's guarantor seems to have a credit standing in fine with their reported income. For example, if the patient reports $1,000 of gross income per month but is making a large mortgage payment along with several credit card payments, the Hospital should require further income verification. If a credit report is not available, document that fact in the patient notes. No further effort is required.

COMMUNICATION

The Hospital is required to post signs in the business office, the admitting and registration areas and the emergency department that inform patients about their financial assistance policies and the availability of charity discounts. Additionally, patient statements must include standard language informing patients that they may request financial screening to determine eligibility for charity discounts and how that request may be made. Finally, the Hospital must prominently post their financial assistance/charity policies on their websites. To the extent possible, these communications should be in the primary language of the patient.

Before commencing any collection activity against a patient, the Hospital must provide a plain language summary of the patient's rights pursuant to AB 774 and the Rosenthal Fair Debt Collection Practices Act. The summary language will be sufficient if it appears in substantially the following form: state and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9 p.m. In general, a debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at www.ftc.gov." You must also include a statement that nonprofit credit counseling services may be available in the area. The above wording will be incorporated into a data mailer attachment and be included in the initial data mailer for all patient liabilities.

Once a charity determination has been made, the outcome must be communicated to the patient. That communication should be accomplished by sending the patient Exhibit A (English or Chinese).

APPEALS

Patients have the right to appeal Hospital charity decisions. Patients must provide written appeals outlining the reasons they believe the charity determination was incorrect. The Hospital CFO is responsible for reviewing all appeals and making a final determination. This authority may be delegated by the CFO to the Hospital Revenue Cycle Manager. The final determination must be communicated to the patient in writing.

OSHPD REPORTING

Per Section 127435 of the Health and Safety Code, the Hospital must provide OSHPD with a copy of the documents outlined below. OSHPD reporting will be the responsibility of the Patient Financial Services department.

- Charity care policy
- Discount payment policy (partial charity or sliding fee schedule)
- Eligibility procedures for these policies
- Review process
- Application form

The documents must be provided at least every other year on January 1, or when a significant change is made. If no significant change was made to the policy since the information was previously provided, it may notify OSHPD of the lack of change to satisfy this requirement. OSHPD has the authority to require electronic submission and is required to make all information available to the public.

Confidential Financial Statement (Application)

Patient Name:	Date of Service:
Patient Number:	

Responsible Party

Name	Marital Status	Social Security Number
Street Address, City, State, Zip	How long at this address	Home Phone
Employer Name and Address		Business Phone
Position/Title	Monthly Income - Gross	Monthly Income – Net
Length of current employment		

Spouse

Name		Social Security Number
Employer Name and Address		Business Phone
Position/Title	Monthly Income – Gross $	Monthly Income – Net $
Length of current employment		

Dependents

Name and year of birth of all dependents in household	Total number of dependents	Do any other Persons contribute? (Yes/No): If yes, Amount: $

Income per Month and Assets

Dividends, Interest	$	Child Support/Alimony	$
Public Assistance/Food Stamps	$	Rental Income	$
Social Security	$	Grants	$
Workers Compensation	$	IRA	$
Savings	$	Other	$

Expenses per Month

Mortgage / Rent Payment	$	Own Home? (Yes / No):	
Mortgage Balance	$		
Food	$	Medical / Dental	$

Utilities	$	Doctor - Name	$
Electric	$	Doctor - Name	$
Gas	$	Doctor - Name	$
Water / Sewer	$	Credit Cards	$
Trash	$	Visa Limit	$
Phone	$	MasterCard Limit	$
Cable	$	Discover Limit	$
Auto Payments	$	Other Limit	$
Auto Expenses	$	Installment Loans	$
Insurance	$	Child Support / Alimony	$
Auto Premium	$	Miscellaneous expenses	$
Life Insurance	$		
Health Insurance	$		

OFFICE USE ONLY
Gross Income_____
Net Income _____
Total Expenses_____
Total Net Income/(Loss)_____

To my knowledge the information provided above is true. I authorize a Credit Bureau Report to be secured by the Hospital or its agent to verify my financial standing.

_____ _____
PATIENT/GUARANTOR SIGNATURE DATE

Exhibit A

CHINESE HOSPITAL

845 JACKSON STREET, SAN FRANCISCO, CA 94133

Chinese Hospital
845 Jackson Street
San Francisco, CA 94133

Date

Guarantor Name
Guarantor Address

RE: Account Number:
Patient Name:
Dates of Service:
Account Balance:

- ☐ Your account has been reviewed for possible charity assistance. After review of all of your submitted financial documentation it has been determined you do meet eligibility guidelines for full charity assistance on this account.
- ☐ Your account has been reviewed for possible charity assistance. After review of all of your submitted financial documentation it has been determined you do not meet eligibility guidelines for full charity assistance on this account.
- ☐ Your account has been reviewed for possible charity assistance. After review of all of your submitted financial documentation it has been determined you meet eligibility guidelines for partial charity assistance on this account. (account balance) is the remaining portion, which is your responsibility to pay.

If you believe this decision is in error, you have the right to submit an appeal. Your appeal must be made in writing, addressed to the Patient Financial Services Director and mailed to the address on this letter.

If you have any questions, please feel free to contact us at 415-982-2400 during normal business hours.

Patient Financial Services Department
Chinese Hospital
415-982-2400