SAN ANTONIO REGIONAL HOSPITAL	Department: **Hospital Policy/Procedure Manual**				
	Section: **Policies and Procedures, Hospitalwide**				
	Title: **Financial Assistance/Charity**				
	Number: **8610.03040**				**Page 1 of 14**
	X Hospitalwide	Interdepartmental	Department	Patient Care	**X** Non- Patient Care

Policy History		Approval: Dates
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PURPOSE:

This policy defines the San Antonio Regional Hospital (SARH) Financial Assistance Program including its criteria, systems, and methods.

Nonprofit acute care hospitals must comply with the California Hospital Fair Pricing Act (codified in California's Health & Safety Code Sections 127400) and with Section 501(r) of the Internal Revenue Code requiring written policies providing discounts and charity care to financially qualified patients. This policy provides for both charity care and discounts to patients who financially qualify under the terms and conditions of this Financial Assistance Program.

The SARH Finance Department has the responsibility for general accounting policy and procedure. Included within this purpose is duty to ensure the consistent timing, recording and accounting of transactions. The Patient Access and Patient Accounting staff is responsible for assisting the patient with the financial assistance application as needed.

POLICY:

This policy applies to all emergency and other medically necessary care provided by the hospital facility. SARH is committed to providing financial assistance to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. SARH will provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance or for government assistance. Designated management will review individual cases to determine a patient's eligibility for financial assistance and determine the discount for which the patient qualifies. All requests for financial assistance from patients, patient families, physicians, or hospital staff shall be addressed in accordance with this policy.

I. According to this written policy:

   A. Every registered patient receives a written notice of SARH's Financial Assistance Policy written in plain language per IRC 501(r).
   B. Upon request, paper copies of the financial assistance policy, the financial assistance application form, and plain language summary of the financial assistance policy are made available free of charge at the SARH Cashier Office, Patient Access Office, Emergency Room Registration, or at the off-site Patient Financial Services office. These items are also available at the SARH web site at *https://www.sarh.org/patients_and_visitors/billing/*

C. Whenever possible, during the registration process, uninsured patients are screened for eligibility with government sponsored programs and/or Hospital's Financial Assistance Program.
D. Public notices are posted throughout the Hospital notifying the public of financial assistance for those who qualify.
E. Guarantor billing statements contain information to assist patients in obtaining government sponsored coverage and/or financial assistance provided by the Hospital.
F. SARH will make available a list of non-employed providers of medically necessary care in the hospital facility that are not covered under this Financial Assistance Policy. That list can be found online at *https://www.sarh.org/patients_and_visitors/billing/.*

II. This policy addresses definitions, financial assistance eligibility criteria, financial assistance discount qualification criteria, application submission and review process, partial charity discount methodology, reporting, and general billing provisions.

A. **Amounts Generally Billed (AGB):** The amount generally billed by the hospital for emergency and other medically necessary services to patients who have health insurance.
B. **Essential Living Expenses:** Expenses for any of the following: rent or house payments (including maintenance expenses), food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child and spousal support, transportation and automobile expenses (including insurance, fuel, and repairs), installment payments, laundry and cleaning expenses, and other extraordinary expenses.
C. **Full Charity:** A discount representing 100% of billed charges when the patient is uninsured and equivalent to the patient's unmet deductible, coinsurance, and/or copay when the patient is insured.
D. **Income:** The sum of all the wages, salaries, profits, interest payments, rents and other forms of earnings received by all members of a patient's family during one year period of time, This includes gross receipts less cost of goods sold for self-employed family members.
E. **Necessary Services:** Inpatient, outpatient, or emergency medical care that is deemed medically necessary by a physician. Necessary services would not include purely elective services for patient comfort and/or convenience, including but not limited to a cosmetic lens implanted during a cataract surgery.
F. **Patient's Family Size:** Is dependent on the age of the patient as defined below
    1. For patients 18 years of age and older, the patient's family includes the patient's spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not.
    2. For patients under 18 years of age, the patient's family includes the patient's parents, caretaker relatives and other children less than 21 years of age.

PROCEDURE

I. Financial assistance eligibility is based upon the patient's ability to pay as determined by the Patient's Family Income relative to the current Federal Poverty Level. The primary eligibility categories are:

A. The patient is uninsured, the patient's liability is not a Medi-Cal Share of Cost or unmet deductible, coinsurance and/or copay related to subsidized coverage provided through a Covered California qualified health plan or similar plan.
B. Patient does not qualify for other income-based/means, government sponsored coverage. A pending application for another healthcare coverage program shall not preclude eligibility for financial assistance under this policy, however, final approval of financial assistance may be deferred until the pending application is processed and eligibility is determined.
C. Patient completes and submits a Financial Assistance Application. Patient submits all required and requested documents and responds to any questions that arise from the Financial Assistance Application.

II. A patient who is deemed eligible for financial assistance or any other discount under this policy will not be charged for emergency or other medically necessary care more than amounts generally billed (AGB) to individuals who have insurance covering such care.

III. Once eligibility is established, the discounted amount and/or discounted balance is determined as defined in the following sections of this policy depending upon the patient's eligibility category and the patient's family income.

Presumptive Charity for Financial Assistance

I. SARH understands that certain patients may be non-responsive to the financial assistance application process. Under these circumstances, SARH may utilize other sources of information to make an individual assessment of financial need. The information will enable SARH to make an informed decision on the financial need of non-responsive patients utilizing the best estimates available in the absence of information provided directly by the patient.

II. SARH may utilize a State approved third-party to conduct an electronic review of patient information to assess financial need. This review utilizes a healthcare industry recognized model that is based on public record databases. This predictive model is designed to assess each patient to the same standards and the traditional application process.

III. The electronic technology will be deployed prior to bad debt assignment after in-house collection efforts and all other eligibility and payment sources have been exhausted. This process allows SARH to screen all patients for financial assistance prior to exploring any extraordinary collection actions. The data

returned from this electronic eligibility review will constitute adequate documentation of financial need under this policy.

Full Charity Discount Criteria

I. The only determination for a patient qualifying for charity care will be according to gross income levels as compared to the published Federal Poverty Guidelines, which are published in the Federal Register in January of each year. The size of the family unit includes the patient, spouse, and any dependents for which the patient has a legal financial obligation. Families with income up to 300% of the Federal Poverty Guideline (FPG) receive hospital services at no cost to the patient.

Partial Charity Discount Criteria

I. Charity Care Discount for hospital services for eligible patients are based on the following guidelines:

A. Family incomes from 301% up to 400% of the Federal Poverty Guidelines receive a sliding scale reduction from the Amounts Generally Billed rate for medically necessary hospital services. The sliding scale is as follows:

FPG	Discount %
Less than or = 300%	100%
301% - 325%	75%
326% - 350%	50%
351% - 375%	25%
376% - 400%	10%

II. Patients below the 400th percentile of the Federal Poverty Level, will not be charged more than amounts generally billed to individuals who have insurance covering the same service. Section 501(r) of the internal Revenue Code (IRC) added by the Affordable Care Act, provides two methodologies to determine the "Amounts Generally Billed", the "Look Back Method" or the "Prospective" method.

III. The "Look Back" method was selected due to the ease of administration to allow all support staff the ability to calculate and quote the patient based on a percentage of charges. The expected payment will be updated each year no later than January 31 summarizing the claims paid in full by Medicare fee-for-service for the preceding calendar year. The reimbursement rate will be calculated by dividing the total collections on the claims paid in full for the proceeding calendar year by the total billed charges on the claims that have been finally determined by Medicare. The rate calculated will be rounded up to the nearest 5/100th of a percent. The reimbursement rates for the calendar year are documented in Addendum A and updated each year and can also be found online at *https://www.sarh.org/patients_and_visitors/billing/.*

Dates of Service Included in Application

I. When the hospital determines that a patient qualifies for Financial Assistance, that determination will apply to the specific services and service dates for the patient or the patient's family representative submitted the application.

II. In the case of continuing care related to the patient diagnosis that requires ongoing, related services, the hospital will treat continuing care as a single case for which qualification applies to all related ongoing services provided by the hospital. At the patient's request, other preexisting patient account balances with service dates within the previous 180 days of qualification are eligible for write-off in accordance with the preceding eligibility criteria.

Other Eligible Circumstances qualifying for Charity: Reassignment for Bad Debt to Charity

I. Any account returned to the hospital from a collection agency that has determined the patient or family representatives does not have the resources to pay his or her bill, may be deemed eligible for Charity Care.

II. Documentation of the patient or family representative's inability to pay for services will be maintained in the Charity Care file.

Payment Plans

I. When a determination of discount partial charity has been made by the hospital, the patient shall have the option to pay any or all outstanding amounts due in one lump sum payment, or through a scheduled term payment plan. The hospital will discuss payment with the patient that requests to make arrangements for term payments. Individual plans will be negotiated between the hospital and patient based upon the patient's ability to effectively meet the payment terms. As a general guideline, payment plans will be structured to last no longer than 12 months. The hospital shall negotiate in good faith with the patient; however there is no obligation to accept the payment terms offered by the patient. If the patient and the hospital are unable to agree on negotiated payment terms, the hospital shall offer the patient the default payment plan. The patient's monthly payment shall not exceed 10% of the patient's family income for one month, excluding deductions for 'essential living expenses" as defined above.

II. Eligible patients are offered a reasonable, extended payment plan. If an agreement is not reached, a reasonable payment formula similar to the hospital's payment formula defined in the Payment Plans section within this policy must be used in determining the monthly payment. A patient may obtain additional information regarding the emergency physicians discount policy by contacting Mountain View Physicians billing service at (877) 484-3035.

Application for Financial Assistance

I. The SARH Financial Assistance Program utilizes a single, unified patient application for both Full Charity Care and Discount Partial Charity Care. The process is designed to give each applicant an opportunity to receive the maximum financial assistance benefit for which they may qualify. The financial assistance application provides patient information necessary for determining patient qualification and such information will be used to qualify the patient or family representative for maximum coverage under the SARH Financial Assistance Program. The financial assistance application should be completed as soon as there is an indication that the patient may be in need of financial assistance. The application form may be completed prior to service, during a patient stay, or after services are completed and patient has been discharged. A copy of the application can be found online at *https://www.sarh.org/patients_and_visitors/billing/.*

Completed applications should be mailed to:
San Antonio Regional Hospital
Attn: Financial Assistance
8301Elm Ave. #300
Rancho Cucamonga, CA 91730

II. The hospital will provide guidance and/or direct assistance to patients or their family representatives as necessary to facilitate completion of program applications. Financial counselors, eligibility services liaisons and/or patient account representatives are available to provide guidance over the phone or meet in person.

III. The application will cover all outstanding guarantor balances at the time the application is completed. Patients may be required to re-apply for financial assistance at least every 180 days.

IV. Applications will be accepted for up to 240 days after the first post-discharge billing notice.

Required Documentation

I. Eligible patient may qualify for the SARH Financial Assistance Program by following application instructions and making every reasonable effort to provide the hospital with documentation and health benefits coverage information such that the hospital may make a determination of the patient's qualification for coverage under the program. Eligibility alone is not an entitlement to coverage under the SARH Financial Assistance Program. To determine eligibility and to maximize the qualifying assistance/discount amount, the following documentation is required when applicable:

A. Completed and signed financial assistance application

B. Current pay stubs from the last two pay periods or if self-employed, current year-to-date profit & loss statement to determine current income.
C. Award letters for social security, SSI, Disability, Unemployment, General Relief, Alimony, etc.
D. For full charity, last calendar year's filed tax return with all required schedules (e.g. W-2 Form).
E. For full charity only, copies of prior year's 1099 for interest income, dividends, capital gains, etc.

Completion of the Financial Assistance Application provides:

I. Information necessary for the hospital to determine if the patient has income sufficient to pay for services.

II. Documentation useful in determining qualification for financial assistance.

III. An audit trail documenting the hospital's commitment to providing financial assistance.

Approval Process

I. The patient or patient's representative shall submit the financial assistance application and required supplemental documents to the SARH Patient Financial Services (PFS) Department. The PFS department's contact information is clearly identified in the application instructions.

II. SARH PFS staff will review financial assistance applications for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient's need for a timely response.

III. Upon receipt of a completed financial assistance application, assigned staff in Patient Financial Services will prepare a "Request For Charity Write Off" Form attaching all supporting documentation as defined within this policy and submit to an applicable manager based upon the amount of the discount requested as defined below.

IV. For the circumstances defined below which do not require submission of a financial assistance application, the staff will prepare a "Request for Charity Write Off" form noting the reason an application was not prepared and attaching a credit report if a valid social security number is available.

V. A financial assistance determination will be made only by approved hospital staff according to the eligibility criteria specific to the patient and the amount of financial assistance requested. Financial assistance shall not be provided on a discriminatory or arbitrary basis. The hospital retains full discretion, consistent with laws and regulations, to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.

Reasons for Denial of Assistance

I. The SARH Financial Assistance Program relies upon the cooperation of individual patients who may be eligible for full or partial assistance. Financial assistance may be denied for failure to submit applicable required documentation.

II. The hospital may deny financial assistance for reasons including, but not limited to, the following:

A. Patient is not eligible for partial charity discounted care based on amount of income
B. Patient is uncooperative or unresponsive, preventing the hospital from determining financial assistance eligibility and qualification
C. Service provided to a full charity care patient is not considered medically necessary.
D. Application is incomplete
E. Patient's balance results from withholding from the Hospital an insurance payment.
F. Patient meets eligibility for income based government sponsored coverage but failed to apply and/or cooperate with the application process.
G. Assistance was requested on a service provided more than 180 days after the most recent request for assistance was approved.
H. Patient's liability is a Medi-Cal share of cost or out of pocket expense related to means tested and/or income-based coverage such as a subsidized Covered California qualified health plan.

III. The financial assistance application should be completed as soon as there is an indication the patient may be in need of financial assistance. The application form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged.

IV. For incomplete financial assistance applications received, SARH will provide written notice to the applicant describing outstanding information and providing the telephone and address for PFS, who can assist with the application.

Application Exceptions

I. A completed financial assistance application may not be required in certain circumstances. These circumstances are limited to situation when SARH determines it has sufficient patient financial information from which to make a financial assistance eligibility and qualification decision. Examples of circumstances not requiring a financial assistance application include, but are not limited to:

A. Patient is homeless
B. Patient is a resident at a shelter including but not limited to prototypes and the American Recovery Center

C. Patient's address is the address for the Department of Public Social Services
D. Patient is unknown
E. Patient is receiving General Relief, Cal WORKS or Cal Fresh (documentation required)
F. Patient qualified for Medi-Cal without a share of cost (SOC) during a portion of the confinement or subsequent to their discharge/visit (proof of eligibility required).
G. Non-covered and /or denied services provided to Medi-Cal eligible patients.

Appeal Process

I. In the event that a patient disagrees with the hospital's determination regarding qualification, the patient may file a written appeal for reconsideration with the hospital as follows:

A. The written appeal should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any or all additional relevant documentation to support the patient's claim should be attached to the written appeal.
B. All appeals will be reviewed by the hospital PFS Director. The Director shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claim, the Director shall provide the patient with a written explanation of findings and determination.
C. In the event that the patient believes a dispute remains after consideration of the appeal by the PFS Director, the patient may request in writing, a review by the hospital Chief Financial Officer (CFO). The CFO shall review the patient's written appeal and documentation, as well as the findings of the Director of PFS. The CFO shall make a determination and provide a written explanation of findings to the patient. All determinations by the CFO shall be final. There are no further appeals.

Billing Statements

I. Consistent with Health and Safety Code Section 127420, SARH will include the following clear and conspicuous information on a patient's bill.

A. A statement of charges for services rendered by the hospital.
B. A request that the patient inform the hospital if the patient has health insurance coverage, Medicare, Medi-Cal, or other coverage
C. A statement that if the consumer does not have health insurance coverage, the consumer may be eligible for coverage offered through the California Health Benefit Exchange (Covered California), Medicare, Medi-Cal, California Children's Services Program, or charity care.
D. A statement indicating how patients may obtain an application for the Medi-Cal 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. If the patient does not indicate

coverage by a third party payer or requests a discounted price or charity care, then the hospital shall provide an application for the Medi-Cal program, or other state or county funded programs to the patient. This application shall be provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care. The hospital shall provide patients with a referral to a local consumer assistance center housed at legal services offices.

E. Information regarding the financially qualified patient and charity care application, including the following:
   1. 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.
   2. 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.
   3. If a patient applies, or has 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.

Collection Efforts

I. These guidelines are used to maintain the accounts receivable at an acceptable level while establishing a general collection criteria for unpaid dollars in an effort to maintain bad debt as low as possible.

   A. Self-Pay Follow-Up:

      1. All self-pay accounts will receive an itemized statement.
      2. The system will continue to automatically send out at least 5 follow-up statements approximately every thirty days.
      3. Guarantor may also be notified through on- line demand letters of outstanding balance due amounts based on individual dollars and situations.
      4. Accounts where "Returned Mail" is received and SARH is unable to make contact with the patient, may be turned over to outside collection immediately.
      5. Normally unpaid patient due amounts must be paid within 90-120 days from date of service unless the patient has made specific arrangements with SARH.
      6. If no payment or denial is received and the account is 120 days or greater it may be referred to outside collection.
      7. All accounts must run through the entire cycle of Guarantor Statement to become eligible for bad debt transfer.

8. A 30 Day Final Notice will be sent at least 30 days prior to assignment to a collection agency.
9. The Management team of the Patient Financial Services Department is responsible for approving all accounts to be sent to a collection agency and determining that reasonable efforts have been made to determine whether an individual is eligible for financial assistance before engaging in extraordinary collection actions against an individual.

Reporting to Credit Agencies

I. SARH will report outstanding balances to the major credit reporting agencies only after the following actions beyond the collection efforts noted above:
   a. A letter will be sent to the patient at least 30 days prior to reporting which includes a statement that financial assistance may be available and the fact that SARH will be notifying credit reporting agencies of the delinquent balance. We will include the plain language summary of the financial assistance policy.
   b. SARH will make a reasonable effort to orally notify the patient about the availability of financial assistance at least 30 days prior to reporting.
   c. Reporting will be at least 120 days from the date of the first post-discharge billing statement.
   d. SARH will notify presumptive partial charity care recipients of the financial assistance determination, indicate how to apply for additional assistance, and give the recipients a reasonable period of time to apply for more generous assistance.
   e. If a financial assistance application is received within 240 days after the first post-discharge billing notice or within 30 days of the date both the written and oral notices above are provided, whichever is later, SARH will not report to the credit reporting agencies until eligibility is determined. If the applicant is determined to be eligible for financial assistance, SARH will provide an updated billing statement, refund any amounts paid by the patient in excess of the amount due and remove delinquent payments from the patient's credit report.

Public Notice

I. All communications with our patients will follow the EMTALA (Emergency Medical Treatment & Labor Act) guidelines. SARH will provide, without discrimination, care for emergency medical conditions to individuals regardless of whether they are eligible for financial assistance under this policy. SARH will not engage in actions that discourage individuals from seeking emergency medical care such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care.

II. SARH shall post notices informing the public of the Financial Assistance Program. Such notices shall be posted in high volume inpatient, areas and in outpatient service areas of the hospital, including but not limited to the Emergency Department, Inpatient Admissions and Outpatient Registration areas, or other common patient waiting areas of the hospital. Notices shall also be posted at any location where a patient may pay their bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply such assistance.

III. These notices shall be posted in English and Spanish and any other languages that are representative of 5% or 1000 members in the community in the hospital's service area. The notice will state the following:

"*San Antonio Regional Hospital offers discounted payment programs or charity care to financially qualified patients. If you are a self pay patient, or have high medical expenses and believe you may be a candidate for one of the hospital programs, please contact our Financial Assistance Coordinator at (909) 980-9511."*

Access to the Financial Assistance Policy

I. A copy of this Financial Assistance Policy and a plain language summary is available on the Hospital's website at *https://www.sarh.org/patients_and_visitors/billing/*.

II. A hard copy of the policy will be made available to the public at the SARH Cashier's Office, Patient Access Office, Emergency Room Registration, or at the off-site Patient Financial Services Department.

OSHPD Reporting

I. SARH will report actual Charity Care provided in accordance with regulatory requirements of the Office of Statewide Health Planning and Development (OSHPD) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition.

II. To comply with the applicable requirements, the hospital will maintain written documentation regarding its Charity Care criteria, and for individual patients, the hospital will maintain written documentation regarding all Charity Care determinations.

III. As required by OSHPD, Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.

IV. In compliance with OSHPD, adopted regulations approved by the Office Administrative Law on August 8, 2007 (Title 22 Sections 96040-96050), the CFO will submit an electronic copy of its discount payment and charity care policies,

eligibility procedures and review process (as defined and documented in one, comprehensive Financial Assistance Program Policy) and it's Financial Assistance application form to OSHPD at least every other year by January 1, or whenever a significant change to the policy is made.

GENERAL PROVISIONS

I. Equal Opportunity:
   A. SARH is committed to upholding the multiple federal and state laws that preclude discrimination on the basis of race, sex, age, religion, national origin, marital status, sexual orientation, disabilities, military service, or any other classification protected by federal, state, or local laws.

II. Confidentiality
   A. It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy should be guided by these values. The Charity Care documentation will not be reviewed or accessed by staff involved in collection activities.

III. Good Faith
   A. SARH makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate.
   B. Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, or purposely inaccurate information has been provided by the patient or family representative. In addition, SARH reserves the right to seek all remedies, including but not limited to civil and criminal damages from those patients or family representatives who have provided fraudulent or purposely inaccurate information in order to qualify for the SARH Financial Assistance Program.

Policy Approval

I. The Financial Assistance Policy cannot be changed or altered without written approval from the SARH Board of Directors.

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