



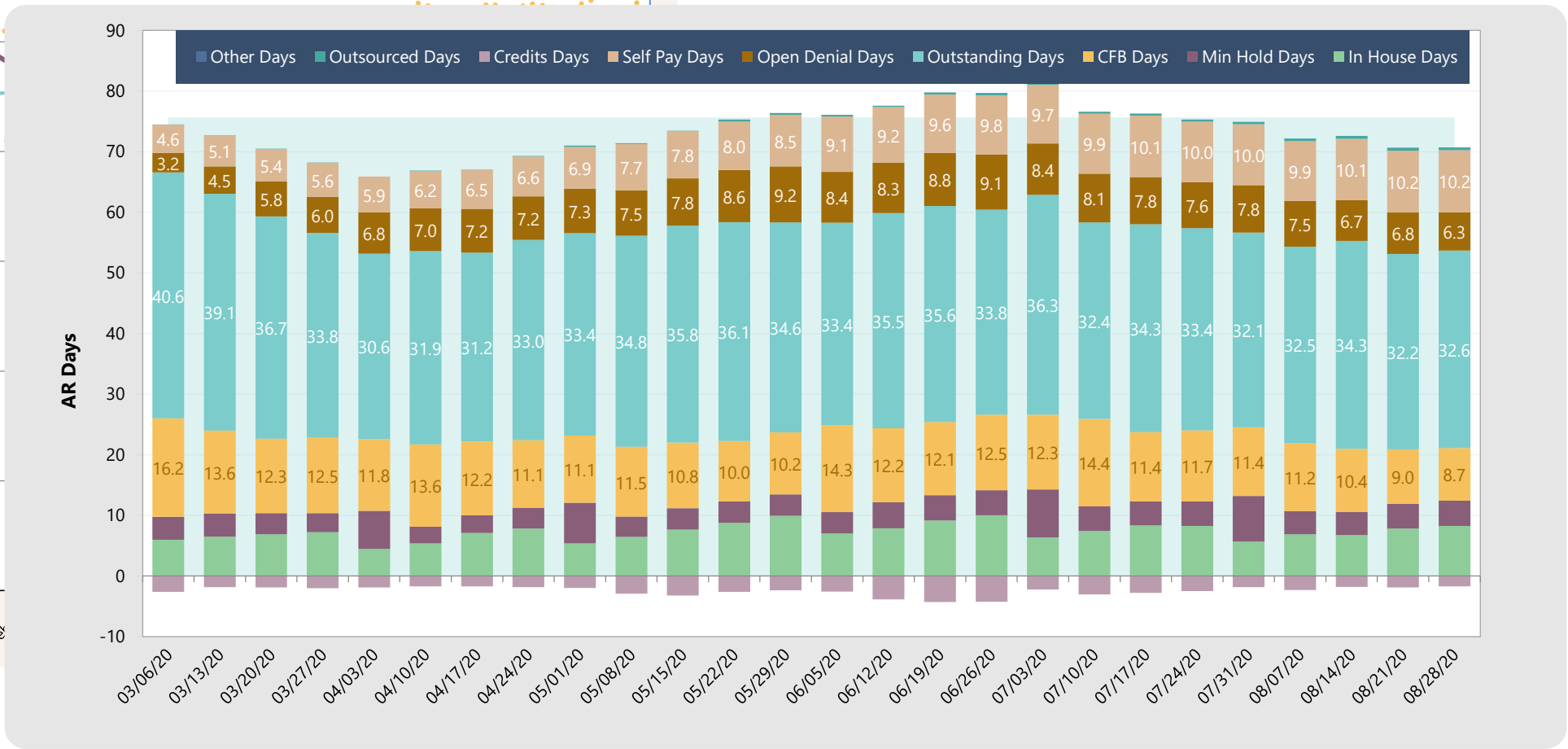
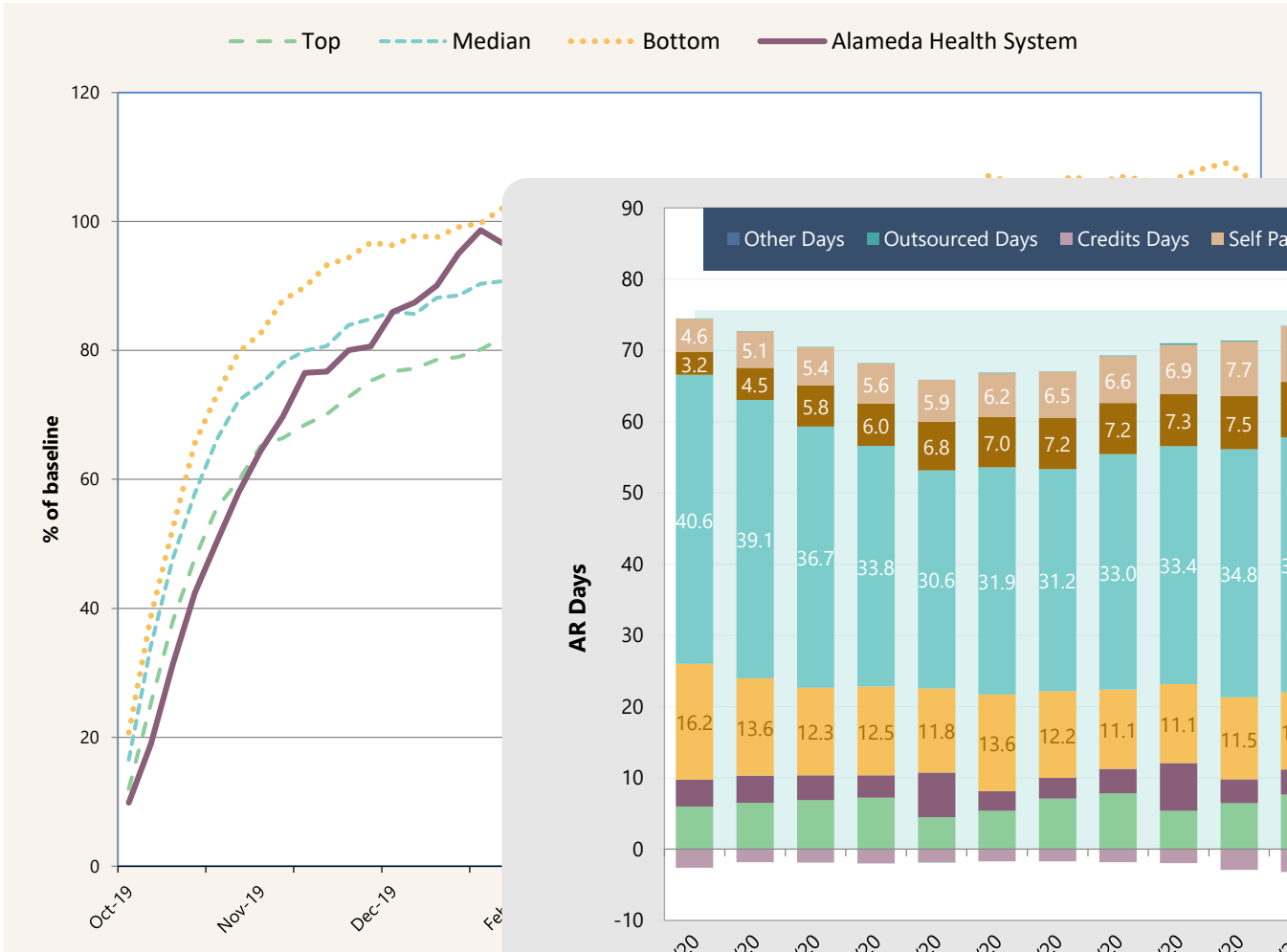
Revenue Cycle Management

August 28, 2020

Introduction

- This is the last time presenting the stabilization dashboard in the current format. We have been live on SAPPHIRE for 1 year and Epic keeps data for new installs for the first 52 weeks which will result in no cross-customer comparisons going forward.
- We will continue to provide updates on the metrics you are used to seeing and there are other ways to compare us to other Organizations.
- COVID has reduced volumes and our Average Daily Revenue. Many of the metric are compared to historical data at go-live skewing results. The adjusted metrics have been restated to reflect the impact of Covid to our charge volume.

Epic Accounts Receivable Hospital Billing



Stabilization Dashboard

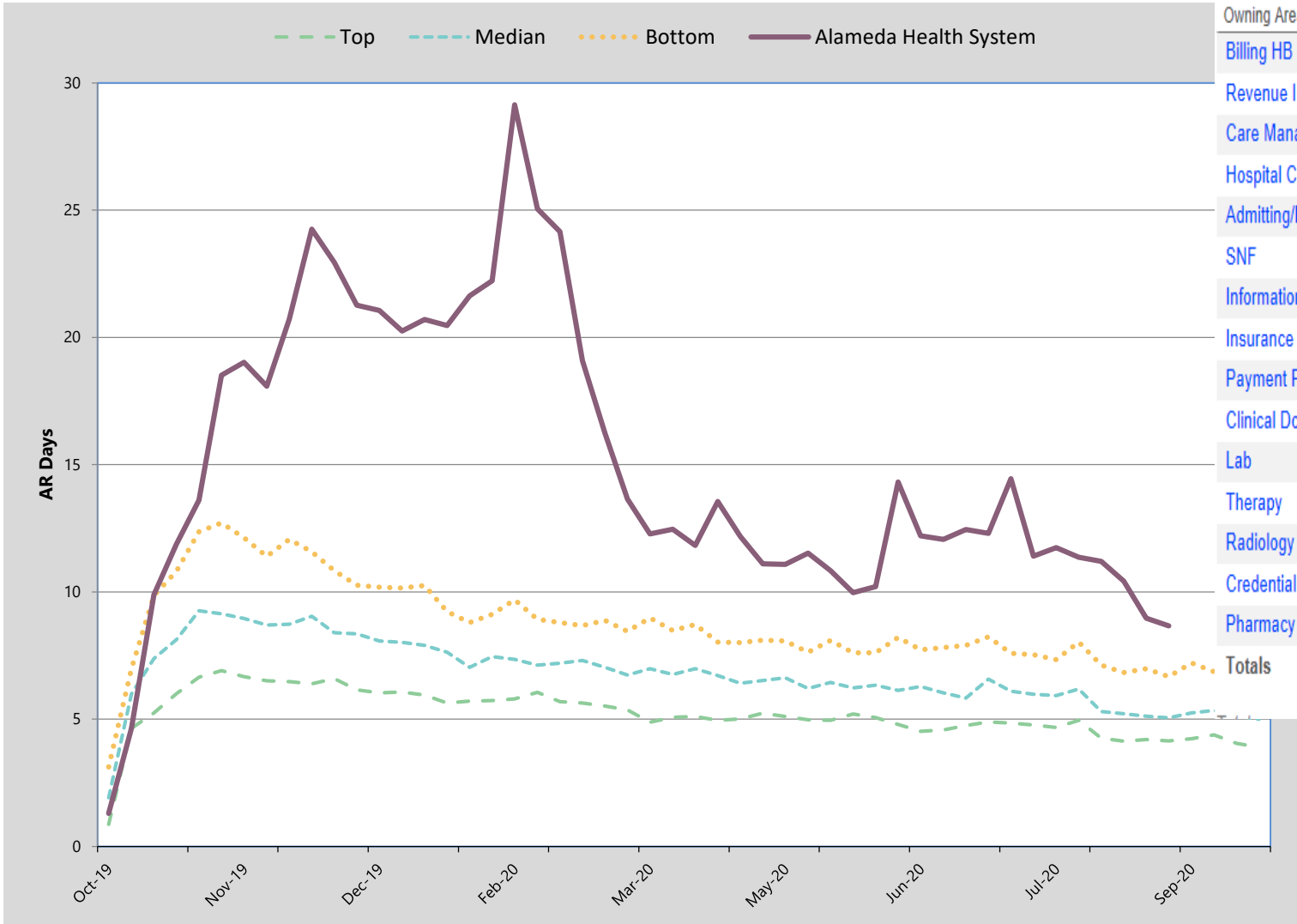


ALAMEDA HEALTH SYSTEM HB STABILIZATION

HB KEY METRICS									
Metric	Status	As of 8/28		As of 8/21		13wk	Bottom	Median	Top
Epic AR Days	▲	68.6 Days	\$539.8M	68.8 Days	\$534.1M		80.1 Days	72.9 Days	67.1 Days
Charging Variance	▼	94.3%	-\$163.2M	94.3%	-\$159.2M		102.6%	105%	108.8%
Payment Variance	▼	-1.5 Weeks	-\$14.7M	-1.5 Weeks	-\$14.7M		0 Weeks	1.5 Weeks	3.2 Weeks
Epic Pmt Avg	▲	103.6%	\$10M	104.7%	\$10.1M		102.8%	107.6%	115.4%
Epic CFB Days	▼	7.8 days	\$67.7M	9 Days	\$69.7M		6.7 Days	5.1 Days	4.2 Days
Coding Days	▲	0.5 Days	\$4.2M	0.5 Days	\$4.1M		1.7 Days	1 Days	0.7 Days
Claim Edit Days	▽	1.5 Days	\$11.7M	1.6 Days	\$12.1M		2 Days	1.1 Days	0.8 Days
Open Denial Days	▼	6.3 Days	\$49.5M	6.8 Days	\$52.9M		3.9 Days	2.9 Days	1.7 Days
Adj Charging Var	▲	101.5%	\$39.2M	101.7%	\$43.2M		102.6%	105%	108.8%
Adj Payment Var	▽	1.3 Weeks	\$12.5M	1.3 Weeks	\$12.1M		0 Weeks	1.5 Weeks	3.2 Weeks

Status Key:		Bottom	Threshold for the 35th percentile for the metric at week 48
▲ = Better than top 25%	▽ = Below median	Median	Median value for the metric at week 48
▲ = Better than median	▼ = In the bottom	Top	Threshold for the 75th percentile for the metric at week 48

CFB



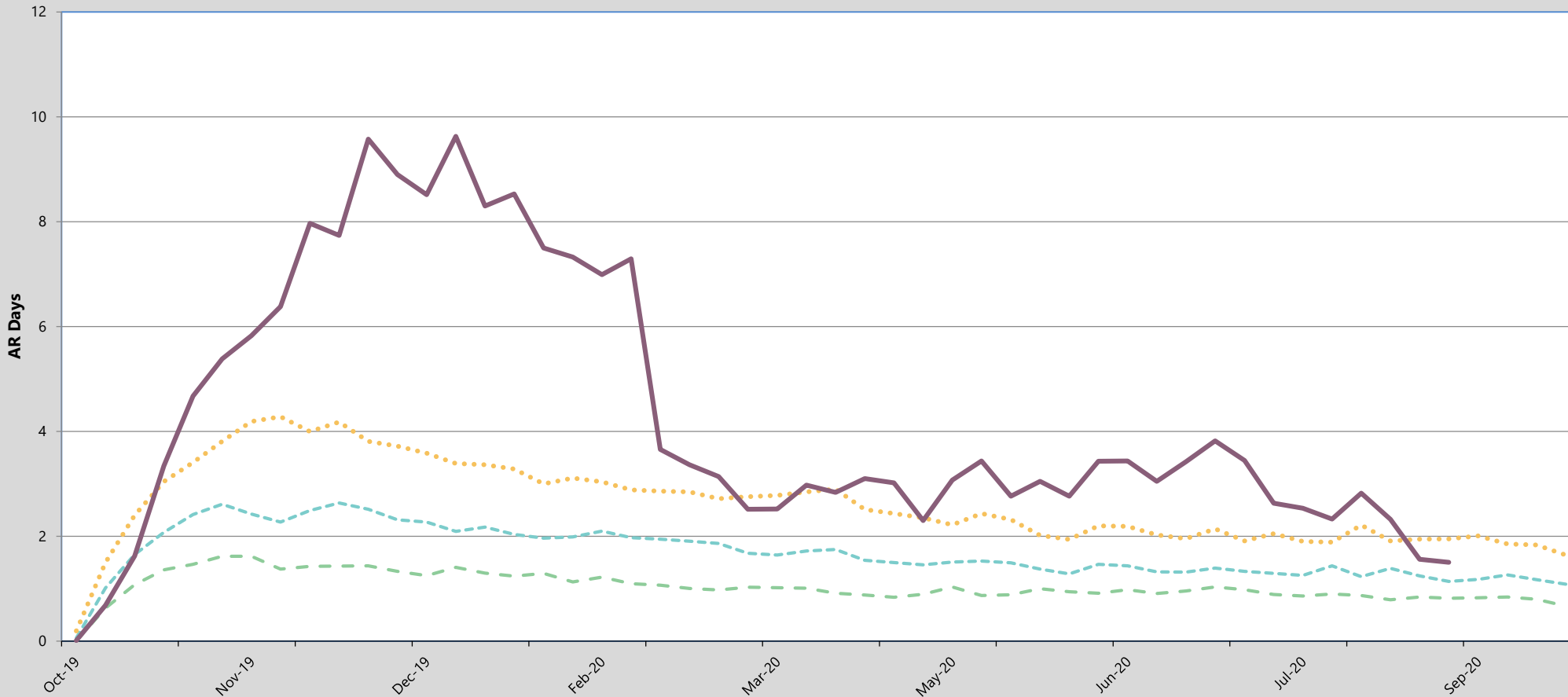
Owning Area	Disch Age	Count	Amt (7 Days)	Amount ▼
Billing HB	126	1,353		23,748,124
Revenue Integrity	191	3,063		18,433,266
Care Management	63	121		9,212,882
Hospital Coding	32	364		5,757,682
Admitting/Registration	78	709		4,145,868
SNF	109	99		3,588,952
Information Technology	239	742		956,577
Insurance Follow-up	289	4		470,650
Payment Posting	313	1		457,594
Clinical Documentation Improvement	5	1		416,396
Lab	38	68		345,823
Therapy	31	2		210,329
Radiology	47	24		81,217
Credentialing	75	11		18,427
Pharmacy	95	1		98
Totals	159	6,307		59,141,456

HB Claim Edits

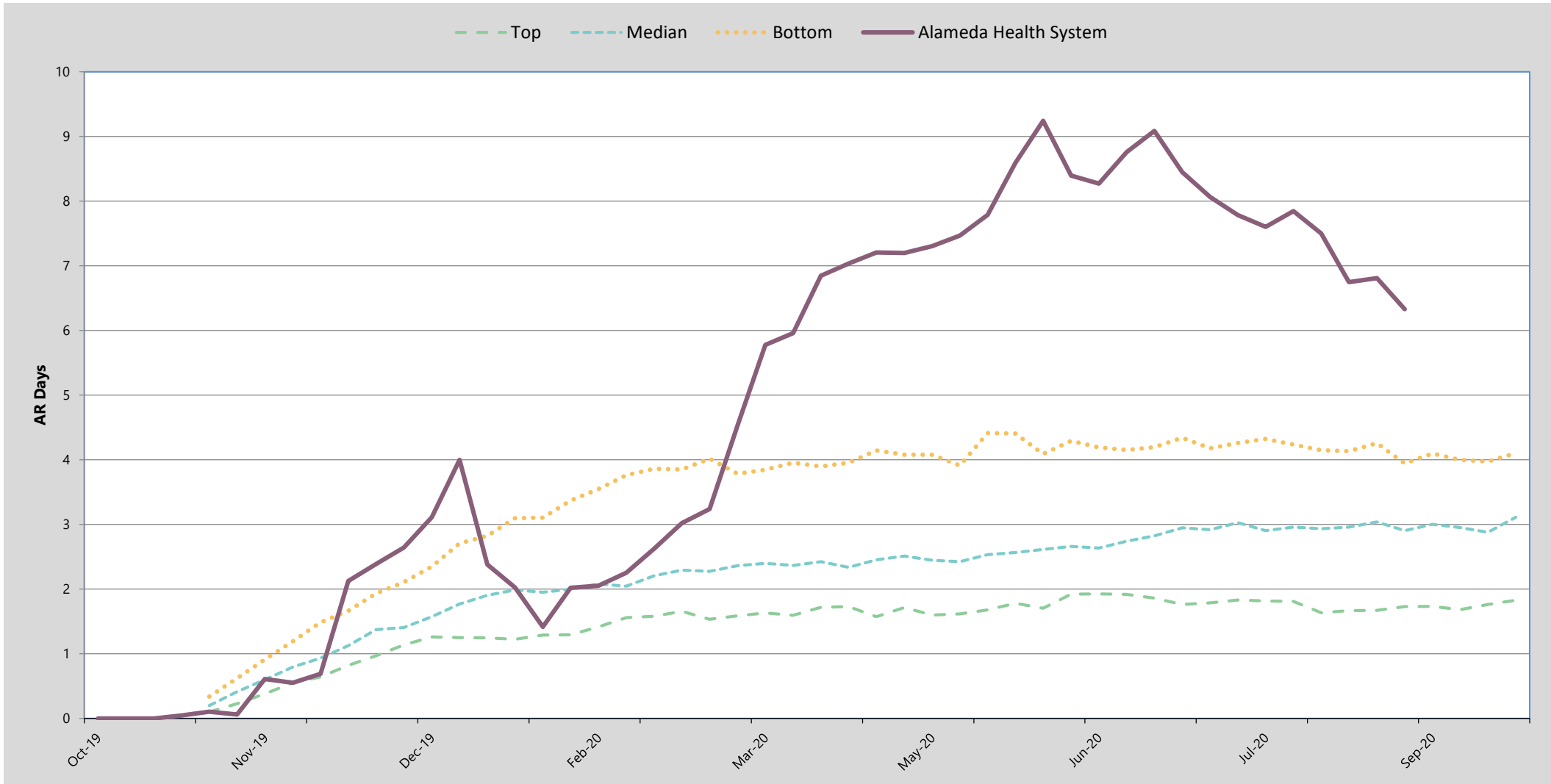


HB Claim Edits

--- Top - - - Median Bottom — Alameda Health System



HB Open Denials



Stabilization Dashboard

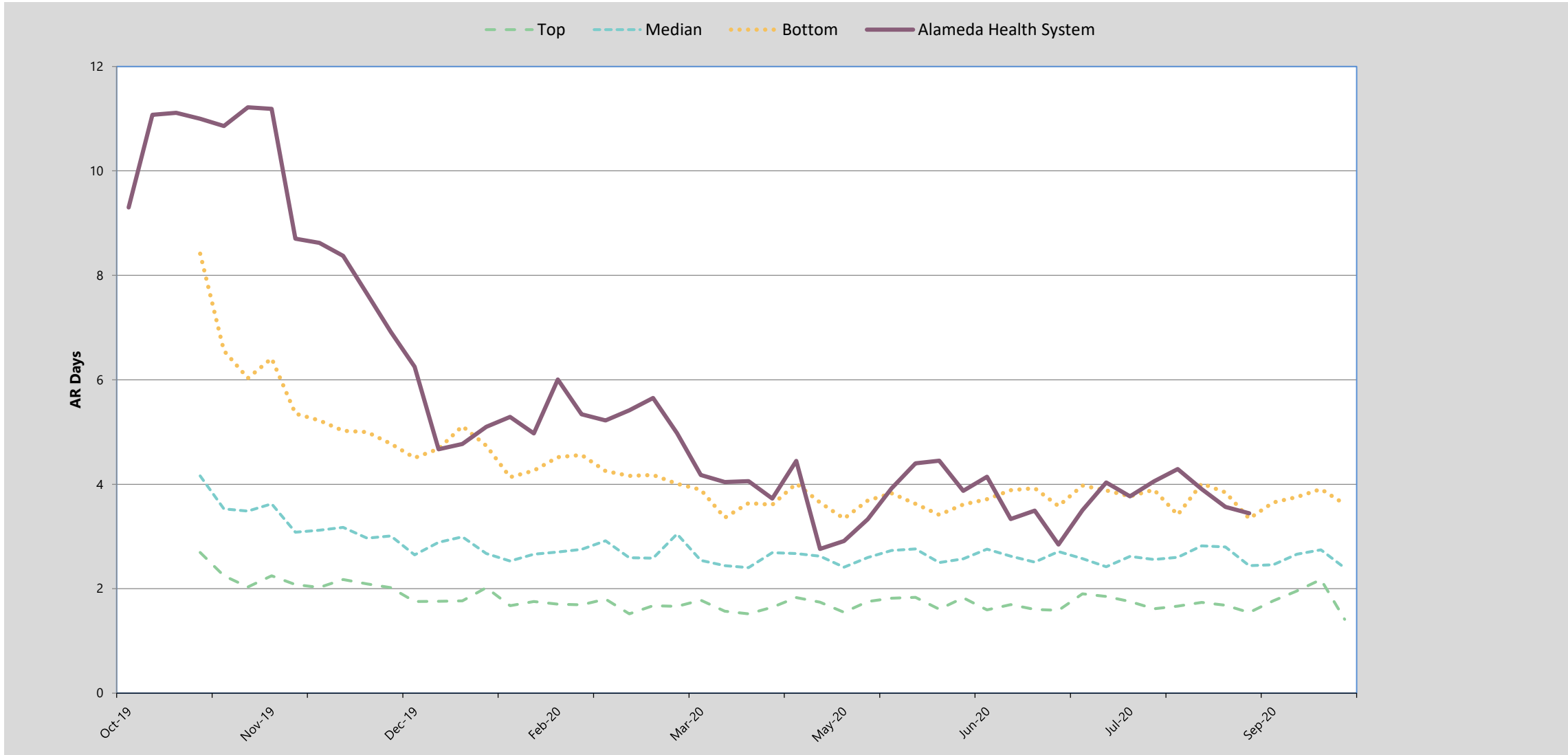


ALAMEDA HEALTH SYSTEM PB STABILIZATION

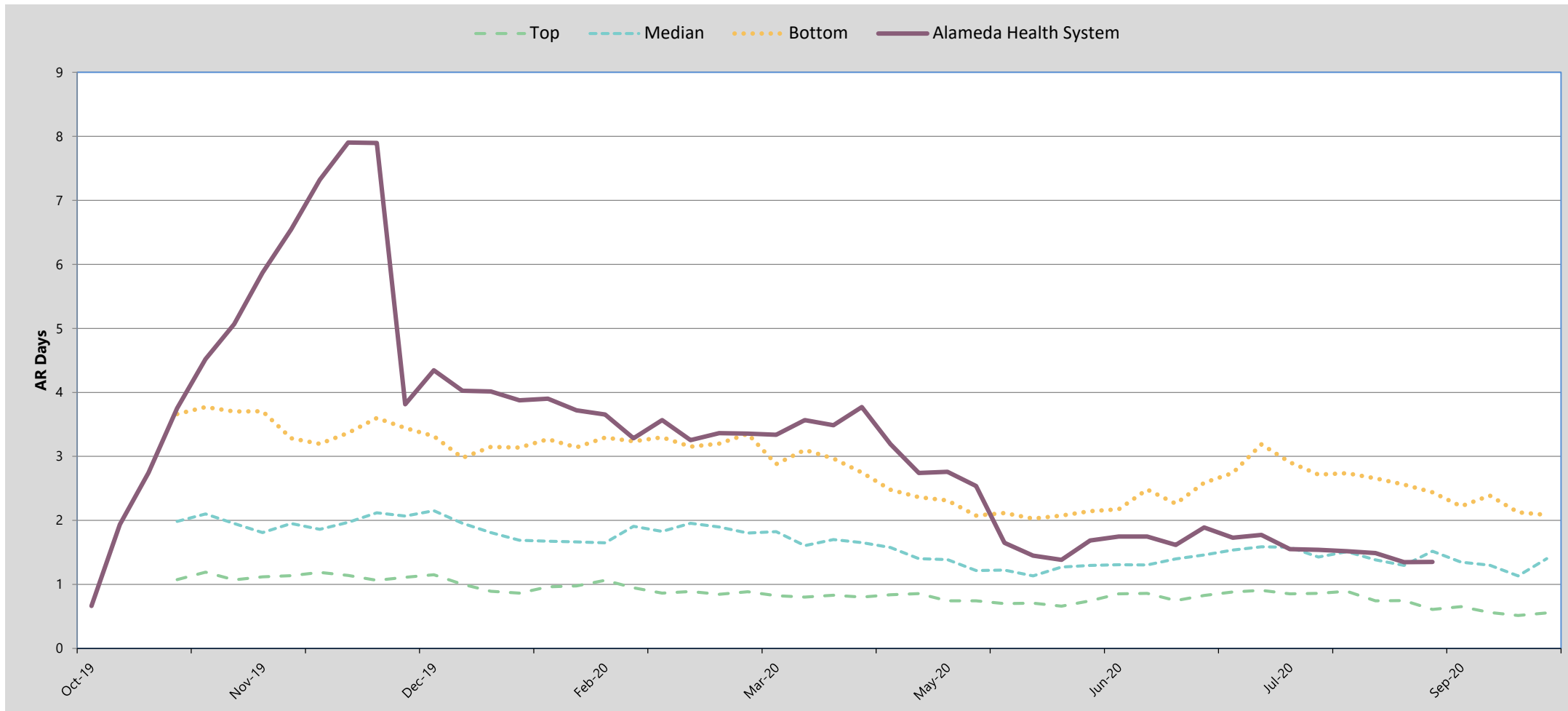
PB KEY METRICS									
Metric	Status	As of 8/28		As of 8/21		13wk	Bottom	Median	Top
Epic AR Days	△	47.6 Days	\$38.8M	47.5 Days	\$38.2M		64.3 Days	55.3 Days	45.9 Days
Adj Charging Var	△	104.4%	\$11.6M	104.6%	\$11.8M		102.9%	105.5%	111.6%
Payment Variance	△	3.1 Weeks	\$3.5M	3.1 Weeks	\$3.5M		-0.1 Weeks	1.6 Weeks	4.2 Weeks
Epic Pmt Avg	△	107.8%	\$1.2M	100.5%	\$1.1M		98.9%	109%	119.4%
Pre-AR Days	▼	3.4 Days	\$2.8M	3.6 Days	\$2.9M		3.3 Days	2.4 Days	1.5 Days
Claim Edit Days	△	1.4 Days	\$1.1M	1.3 Days	\$1.1M		2.4 Days	1.5 Days	0.6 Days
Open Denial Days	▼	8.3 Days	\$6.7M	8.2 Days	\$6.6M		7.8 Days	5.3 Days	3.5 Days
Undistributed Days	▼	8.9 Days	\$1.6M	9.6 Days	\$1.6M		4.6 Days	3 Days	1.9 Days
Adj Charging Var	△	104.4%	\$11.6M	104.6%	\$11.8M		102.9%	105.5%	111.6%
Adj Payment Var	▲	5.7 Weeks	\$6.5M	5.6 Weeks	\$6.3M		-0.1 Weeks	1.6 Weeks	4.2 Weeks

Status Key:		Bottom	Threshold for the 35th percentile for the metric at week 48
▲ = Better than top 25%	▽ = Below median	Median	Median value for the metric at week 48
△ = Above median	▼ = In the bottom	Top	Threshold for the 75th percentile for the metric at week 48

PB Pre-AR



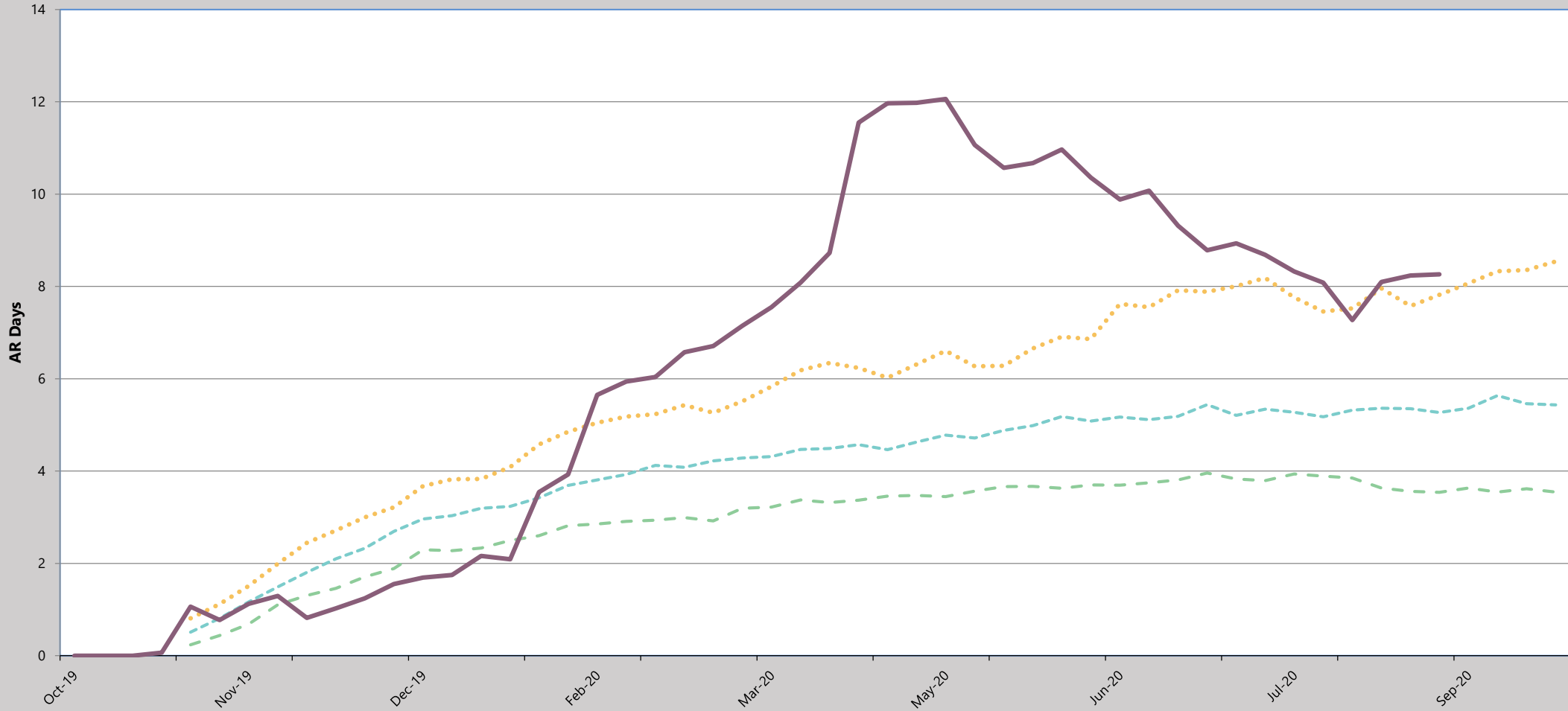
PB Claim Edits



PB Denials



Top Median Bottom Alameda Health System



Revenue Cycle Management

- Key Metrics

- Our AR days, CFB and Open Denials have decreased significantly and continue on a downward trend
- We are doing well trending in the right direction. More work is needed but we are positive we can reach our goals
- The staff is excited and motivated about our results and we are celebrating and building on our successes.

- Initiatives

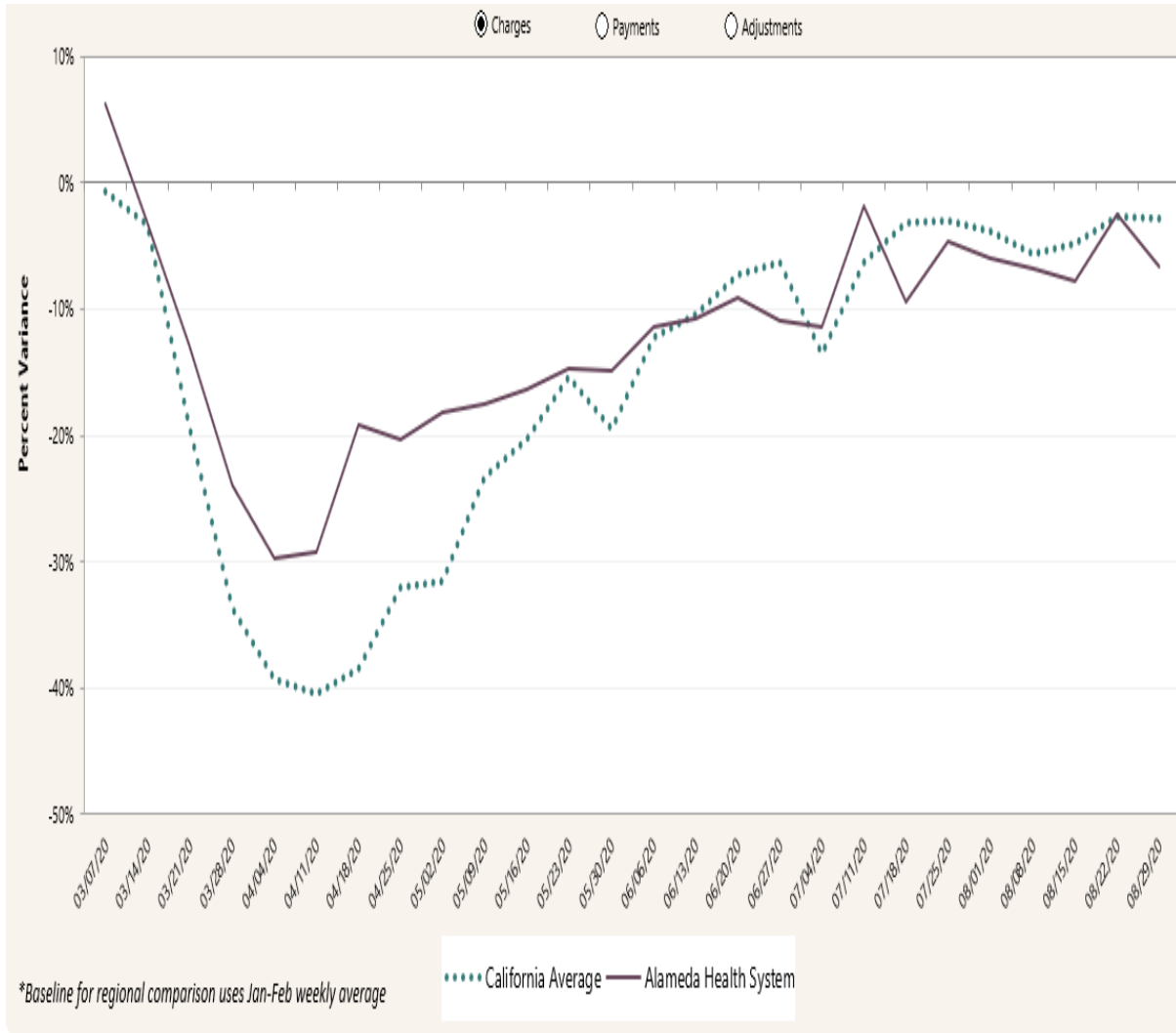
- Many workgroups and forums underway daily with all key stakeholders in the organization to collaborate and improve our metrics.
- Daily focus on Denial and CFB as reduced our AR days and increased our cash collections.
- Working to ensure compliance with Price Transparency Regulation effective 1/1/21

Revenue Cycle Management

- Significant work is dedicated to the root cause analysis of our open denials.
 - Weekly workgroup meeting
 - Attendance and collaboration from many department in the Organization
 - Action items are developed and brought forward to resolve
 - From 7/10 – 9/4 there was a decrease of \$13,408,745 in open denials. As of 9/4 we were at 6 days.
 - We are excited about our trend in the right direction and work to compare ourselves to the top performer in the future.

COVID-19 Impact Comparisons Charges as a % of Baseline Compared to California Hospitals

Hospital Billing



Professional Billing





**Charity Care Policy
Debt Collection and Collection Agency
Management Policy
September 10, 2020**



Charity Care Policy Overview

- To ensure no patient will be denied service due to an inability to pay. To provide Charity Care to qualified low-income uninsured and underinsured to whom we provide services in our community
 - All patients that meet the criteria threshold at or below 350% of the FPL will be granted 100% charity care
 - Patients who are insured but with high medical costs also may qualify
 - For Patients that are not able to complete their application we use a presumptive eligibility tool to help them qualify.

Charity Care Policy Overview

- We ask for approval of this policy now to ensure we have a Charity Care Policy in place.
- There are changes and updates that need to occur and being worked on now
- Once the changes are made it will come back to this group for approval

Debt Collection and Collection Agency Management Policy

Key Terminology

- Extraordinary Collection Action (ECA) are any of the following
 - Filing lawsuit to collect a debt
 - Seizing a bank account
 - Lien on a residence or other personal property
 - Foreclosure on real or personal property
 - Delay or denial of medically necessary care based on the existence of an outstanding prior balance
 - Reporting adverse information about a patient to a credit agency or a credit bureau
 - Selling of a patient's debt to another party
 - Actions that cause a Patient's arrest
 - Wage garnishment
 - Obtaining an order for examination

Policy Overview

- Ensure AHS collection practices are in compliance with requirements passed by Congress and detailed by IRS 501r Regulations. And to also make sure Collection Agencies acting on behalf of AHS are also in compliance.
 - AHS Collection Agencies do report adverse information to a credit agency/ credit bureau. This is defined as an ECA.
 - AHS will make Reasonable Efforts under the IRS requirement to not employ ECA's during the 120 -day notification period. Defined as 120 days from the first post-discharge billing statement
 - AHS will also make Reasonable Efforts during the application period of 240 days from the first post-discharge billing statement to accept a Charity Care Application, even if we have initiated ECA against the patient
 - Collection Agencies acting on behalf of AHS file a credit report 60 days from the date we place the account with the agency. This is 180 days from first statement to the patient. This ensures compliance.

Policy Overview

Action Items

- Review how billing and collection practices and our Financial Assistance Policies are communicated to our patients.
 - Financial Assistance information is on our patient statements
 - Need to ensure that Financial Assistance is communicated on our website as well as make the application available
 - Ensure a good process is in place for patient questions and complaints. Quick turn around time needed. A Dispute Policy should be created.
- Review all patient statements from a patient's point of view and to also ensure compliance with verbiage
- Make sure that requirements passed by Congress and IRS are adhered to for collection practices and Financial Assistance
- Engage with relevant departments on the details of this policy

Data and Decision Points

- Based on data from one of our Collection Agencies representing half of the alpha:
 - From 1/1/18 – 8/27/20 (32 months) we assigned 36,586 accounts for \$16,684,227M to one Collection Agency
 - The total payments received on these accounts was \$974,252 representing 5112 accounts
 - Of the 36,586 accounts 1,950 were credit reported.
 - Total collections as a result of the credit reporting was \$415,412
 - This is on average of \$12,981 per month (1/2 of the alpha)
 - 44% of payments collected occur after credit reporting
- Decision Point
 - Does AHS want to continue to Credit Report our Patients given the community we serve.

Action for Approval

- After review of our data and taking into consideration the community we serve we bring forward a recommendation to suspend credit reporting at this time.
 - Consideration was given and compared to what other Organizations are doing
 - Our Community and the people we serve
 - Elimination of an Extraordinary Collection Effort (ECA) against our patients
- Track impact over time
- Monitor the impact on future cash collections
- Opportunity to come back and revise our policy if needed



Debt Collection Practices and Collection Agency Management Policy

<i>Department</i>	All	<i>Effective Date</i>	
<i>Campus</i>	AHS System	<i>Date Revised</i>	
<i>Category</i>	Finance	<i>Next Scheduled Review</i>	
<i>Document Owner</i>	VP, Revenue Cycle	<i>Executive Responsible</i>	Chief Financial Officer

Printed copies are for reference only. Please refer to electronic copy for the latest version.

POLICY STATEMENT

This policy applies to Alameda Health System (AHS) and any outside agencies working on our behalf that have the responsibility to bill patients and applicable third party payers accurately, timely, fairly and consistent in accordance with all contractual obligations, laws and regulations including without limitation to the California Health and Safety Code and regulations issued by the United States Department of the Treasury under section 501(r) of the Internal Revenue code. AHS will not threaten or treat our patients or payers with disrespect or with an aggressive tone or behavior. AHS collection practices shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation. AHS shall not deny medically necessary services due to an individual’s inability to pay or knowledge of a previous account in bad debt.

PURPOSE

To assure that consistent collection practices are followed with respect to both patients and payers and that AHS staff, collection agencies and other vendors acting on behalf of Alameda Health System comply with all applicable AHS policies and procedures as well as applicable provisions of California Law and regulations issued by the United States Department of the Treasury under section 501r of the Internal Revenue Code. This policy applies to Alameda Health System and any outside agencies working on our behalf.

DEFINITIONS

For the purpose of this policy, the terms below are defined as follows

A. Extraordinary Collection Action: (ECA)

An Extraordinary Collection Action is any of the following:

1. Any action to obtain payment from a patient that requires a legal or judicial process, including the filling of a lawsuit.
2. Selling a patient's debt to another party including a collection agency
3. Reporting adverse information about a patient to a credit agency or a credit bureau
4. Seizing a bank account
5. Lien on a residence or other personal or real property
6. Foreclosure on real or personal property
7. Actions that cause a Patient's arrest
8. Wage garnishment
9. Delay or denial of medically necessary care based on the existence of an outstanding balance for prior service
10. Obtaining an order for examination

Extraordinary collection action does not include referral to a debt collection agency.

AHS will make "Reasonable Efforts" not to employ ECA's during the 120-day notification period, which is no earlier than 30 days after the date of the notice or 120 days after the first post-discharge billing statement whichever is later. AHS will make reasonable efforts during the application period of 240 days from the first post-discharge billing statement to accept a Financial Assistance Application even if we have initiated ECA's against the patient. An ECA for AHS is defined as Reporting adverse information about a patient to a credit agency or a credit bureau.

B. Financial Assistance/Charity Care

Assistance provided to patients for whom it would be a financial hardship to fully pay the expected out of pocket expense for medically necessary services provided by AHS and who meet the eligibility criteria for such assistance. Under this Policy, Financial Assistance is defined as Charity Care (refer to Charity Care Policy). AHS Charity Care Policy can be obtained by contacting Patient Access or Patient Financial Services Departments, and by various means including the AHS website. (I need to be sure it is on our website)

C. Guarantor

For the purposes of this policy, the individual who is the financially responsible party for payment of an account balance, and who may or may not be the patient.

D Uninsured Patient

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 Worker's Compensation.

E. Self-Pay Discount

Once it has been determined that the patient does not qualify for charity care the patient is eligible for a self- pay discount from total charges.

II. PROCEDURE

- A. AHS will pursue payment for debts owed for health care services provided by AHS according to AHS policy and procedures. The procedures for assignment to collection will be applicable to all AHS Guarantors
- B. AHS will comply with relevant federal and state laws and regulations in the assignment of bad debts.
- C. Billing Third Party Payers
AHS shall diligently pursue all amounts due from third party payers, including contracted and non-contracted payers, and any other HMO, PPO group health Plans Indemnity Insurer or government program payers that may be financially responsible for a patients' care.
- D. Billing Insured Patients
AHS shall promptly bill insured patients for the patient responsibility amount as computed by the Explanation of Benefits (EOB) and directed by the third-party payer. AHS defines promptly billing as 12 months from the time of the payment from the payer. If this time has passed, we will consider the amount not billable to the patient.
- E. Billing Uninsured Patients:
AHS shall promptly bill uninsured patients for items and services provided using our billed charges less the standard self-pay discount for inpatient and outpatient services. This self-pay discount does not apply to patients who qualified for financial assistance/charity care or received services that are already discounted.
- F. Itemized Statements:
A patient may request an itemized statement for their account at any time.
- G. Disputes:
Any patient may dispute an item or charge on their bill. Patients may initiate a dispute in writing or over the phone. Once a dispute is received the account will be placed on hold during the investigation of the dispute.
- H. All patient account balances that meet the following criteria are eligible for placement with a collection agency:
 - 1. AHS has made attempts to collect payment using reasonable collection efforts, such as statements, or telephone calls. AHS will attempt to mail (4) Guarantor statements after the date of discharge from outpatient or inpatient care, with at least 120 days passed since AHS sent the initial bill to the patient. A final 30-day notice appearing on the fourth Guarantor statement, indicating the account may be placed with a collection agency. All billing statements include a notice about the AHS Financial Assistance/Charity Care Policy.
 - 2. Accounts with a "Returned Mail" status are eligible for collections assignment after all good faith efforts have been documented and exhausted

3. If AHS determines that a patient qualifies for Financial Assistance/Charity Care, and the Guarantor has paid AHS more than the amount that should be due from a qualified patient, AHS shall refund the amount actually paid to AHS in excess of the amount due including interest at the rate provided in the Code of Civil Procedure Section 685.010 (currently set at 10 percent annually) from the date of AHS's receipt of the overpayment.
4. Patient balances referred to a collection agency will be recorded as bad debt in the financial and reporting system.

No Collection During Financial Assistance/Charity Care Application Process:

AHS and contracted collection agencies shall not pursue collection from a patient who has applied for financial assistance for 30 days and shall return any amount received from the patient at the time the patient qualifies for financial assistance. Patients shall not be sent to a collection agency if they have been approved to receive charity care under the AHS Charity Care Policy. AHS will not turn an account over to a collection agency without applying self-pay discount for uninsured patients.

Payment Plans:

AHS and any Collection Agency acting on our behalf shall offer uninsured patients and insured patients with a patient responsibility portion the option to enter into an agreement to pay their patient responsibility portion and any other amounts due over time. AHS will also offer extended payment plans for those patients who indicate an inability to pay a patient responsibility amount in a single installment. Terms of Payment Plans: all payment plans shall be interest-free. AHS will negotiate an extended payment plan to allow payments over time that is agreed upon between AHS and the patient based on the patient's family income and essential living expenses. If AHS and the patient are unable to agree on the terms of the payment plan, AHS shall extend a payment plan option under which the patient may make a monthly payment of not more than 10% of the patient's monthly family income after excluding essential living expenses. "essential living expenses" means expenses for any of the following: rent, 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.

Declaring Payment Plan Inoperative

An extended payment plan may be declared no longer operative after the patient's failure to make all consecutive payments due during a 90-day period. Before declaring the payment plan no longer operative, AHS or the contracted 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 that the patient has the opportunity to renegotiate the extended payment plan. After a payment plan is declared inoperative, the Hospital or

contracted collection agency may commence collection activities.

Collection Agency Rules:

1. A Collection Agency's performance and its functions must be consistent with AHS mission, core values and policies, including but not limited to the Charity Care Policy, and the Debt Collection Practices and Collection Agency Management Policy.
2. The contract with the Collection Agency must state whether AHS has authorized the collection agency to file negative credit reports against patients for non-payment.
3. The Collection Agency must have processes in place to identify patients who may qualify for Charity Care, communicate the availability and details of the charity care program to these patients and refer to patients who qualify and are seeking charity care consideration back to the Patient Financial Services Department
4. The Collection Agency shall not seek any payment from a patient who has applied for Financial Assistance/Charity Care and will return any amount received from the patient if approved for charity care.
5. At least 120 days must have passed since AHS sent the initial bill to the patient before it is placed with a contracted Collection Agency.
 - a. The Collection Agency may only attempt to collect the amount outstanding after application of the self-pay discount.
 - b. The Collection Agency may not file a lien against a patient's residence, personal or real property.
 - c. The Collection Agency shall not foreclose on a patients personal or real property.
 - d. A Collection Agency shall not garnish a patient's wages
 - e. A Collection Agency will never serve a patient with an arrest warrant
 - f. Any interest charged by the collection agency must meet requirement and may not exceed an annual rate of 10% interest
 - g. A Collection Agency will never threaten a patient with any of the above comments to collect the debt
 - h. The Collection Agency must agree that it will not engage in any extraordinary collection actions to collect a patient debt.
 - i. Until a payment plan is declared inoperative no report may be made to a consumer credit reporting agency.

Evaluate Agency Performance

1. AHS will evaluate the performance of each Collection Agency at least on an annual basis. Items to consider in this evaluation are the collection experience compared to other years

and other agencies, and comparison to established goals. We will also consider patient reactions, patient complaints.

2. Not less than annually, AHS will evaluate the Collection Agencies business ethics and methods of operations and their compliance with AHS policies.

Assignments of Accounts to Collection Agencies

1. AHS should obtain written statements from the Collection Agencies not less than annually attesting that they are following AHS policy and complying with all state and federal laws and regulations
2. AHS will investigate and analyze patient complaints about the activities of Collection Agency and promptly and thoroughly make and document all necessary corrections.
3. AHS will review Collection Agencies form letters and scripts to ensure they are compatible with AHS mission statement and core values and this policy.

APPROVALS

	System	Alameda	AHS/Highland/John George/San Leandro
Department: Revenue Integrity	N/A		
Pharmacy and Therapeutics (P&T)	N/A	N/A	N/A
Clinical Practice Council (CPC)	N/A	N/A	N/A
Medical Executive Committee	N/A	N/A	N/A
Board of Trustees	N/A	N/A	N/A



CHARITY CARE POLICY

<i>Department</i>	Patient Access Services	<i>Effective Date</i>	03/2004
<i>Campus</i>	AHS System	<i>Date Revised</i>	12/2019, 03/2020
<i>Category</i>	Finance	<i>Next Scheduled Review</i>	08/2023
<i>Document Owner</i>	Director, Patient Access	<i>Executive Responsible</i>	Chief Financial Officer

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PURPOSE

The purpose of this policy is to define the eligibility criteria for Charity Care services and to provide administrative and accounting guidelines to assist with the identification, classification, and reporting of patient accounts as charity care.

POLICY

Alameda Health System will operate in a manner such that no patient shall be denied service due to an individual’s inability to pay. Consistent with this commitment, it is the policy of Alameda Health System (AHS) to provide Charity Care (financial assistance) to qualified low-income uninsured or underinsured patients to whom we provide services in our community. This policy will be administered in a manner consistent with state and federal laws and regulations.

As required by law, AHS shall provide patients with information regarding charity care and other programs during the patient intake process. Patients (and/ or representatives) are expected to cooperate with AHS to determine charity care eligibility and to contribute to the cost of their care based on their ability to pay. It is imperative that the notification of availability, determination, reporting and tracking of charity care are in concert with our mission and our community obligations.

Patients who do not qualify for charity care, but are uninsured, may qualify for the Patient Discount set forth in the current hospital policy separate from this policy.

DEFINITIONS

For the purpose of this policy, the terms below are defined as follows:

Patient’s Family [Health and Safety Code §127400(h)]:

- a) **Patients 18 years of age and older** – **t h e** family includes the patient’s spouse, registered domestic partner and dependent children under 21 years of age.
- b) **Patients under 18 years of age** – **t h e** family includes the patient’s parent, caretaker relatives, and other children (under 21 years of age) of the parent or caretaker relative.

Federal Poverty Level (FPL): FPL means the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services. [H&S §127400(b)]

Self-pay patient: A patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid/Medi-Cal, and whose injury is not a compensable injury for Worker’s Compensation, automobile insurance, or other insurance (third party liability) as determined and documented by hospital. Self-pay patients may include charity care patients. [H&S §127400(f)]

Uninsured patient: An “uninsured patient” is a patient who has no third-party source of payment for any portion of their medical expenses, including but not limited to, commercial or other health insurer, health care service plan, Medicare, or Medicaid/Medi-Cal, or third party liability. For the purpose of this policy an “uninsured patient” may include a “self-pay” patient.

Discount payment: Describes the situation where the hospital has determined that the patient does not qualify for charity care (*i.e.*, free or almost free care), but is eligible for a discount and is expected to pay only a part of the bill.

Patient with high medical cost: Is a person whose family income does not exceed the FPL percent if that individual does not receive a discounted rate from the hospital as a result of his or her third party coverage. [H&S §127400(g)]

Qualified Patient: Means a patient who is both (A) a patient who is a self-pay patient, or a patient with high medical cost, and (B) a patient who has a family income that does not exceed the 350 percent of the FPL. [Health & Safety Code § 127400(c)]

PROCEDURES

I. Determining Eligibility

A. Governmental Assistance

1. In determining whether each individual qualifies for charity care, other county or governmental assistance programs should also be considered. Many applicants are not aware that they may be eligible for assistance such as Medi-Cal, Health PAC, Victims of Crime, California Children Services or the Affordable Care Act benefit plans.
2. AHS shall assist individuals in determining if they are eligible for any governmental or other assistance.
3. Persons eligible for programs such as Medi-Cal, but whose eligibility status is not established for the period during which the medical services were rendered, may be granted charity care for those services. AHS may make the granting of charity care services contingent upon the patient applying for governmental program assistance. This may be prudent, especially if the particular patient requires ongoing services.

B. Criteria for Charity Care Eligibility – Uninsured Patients

A low-income uninsured patient is eligible for Charity Care consideration based on meeting the family income eligibility criteria as established by Alameda Health System’s application of the Federal Poverty Income Guidelines. Full charity care (no payment) applies to all patients at 200% or less of the FPL. AHS has extended the Charity Care services to patients who have family income that does not exceed the 350 FPL. Full discount (“write off”) is provided for individuals and families with annual incomes at or below 200% of the current FPL. Partial discounts are provided for individuals and families with incomes above 200% of the current FPL and at or below 350% of the current FPL. Partial discounts adjust based on gradation in income levels.¹

C. Criteria for Charity Care Eligibility – Insured Patients

Eligibility for Insured Patients

1. A patient who is insured but has “high medical costs” and who is at or below 350% of the federal poverty level (FPL) is eligible to apply for charity care.
2. Charity care applies to the portion of the bill that is the patient’s responsibility.
3. AHS will determine the patient’s Allowable Medical Expenses according to the limiting formula.
4. If a patient has been assigned Medi-Cal share of cost, the share of cost amount may be eligible for charity care.
5. Patients whose income exceeds 350% of the FPL may be eligible to receive discounts based on AHS’s Prompt Payment Discount policy.
6. Insured patients with high deductible plans, high medical costs or limited coverage who have exhausted their benefit coverage may qualify for charity care or discount payment according to the criteria set forth in this policy or our prompt pay discount policy.

D. Income and Monetary Assets of Patient

In determining eligibility under this policy, AHS may consider income and monetary assets of the patient. For purposes of this determination, monetary assets shall not include retirement or deferred compensation plans. Furthermore, the first ten thousand (\$10,000.00) of a patient’s monetary assets shall not be counted in determining eligibility, nor shall fifty percent (50%) 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, etc. [H&S §127401-5]

E. Charity Care Application

a. Application

1. A low-income uninsured hospital patient who indicates the financial inability to pay a bill for a medically necessary service shall be evaluated for charity care assistance or any other federal, state, or county program.
2. The AHS standardized application form, shown as the “Charity Budget Form” (see Attachment A), will be used to document each patient’s overall financial situation. This application should be available in the primary language(s) of service area (*i.e.*, English and Spanish).
3. If an uninsured hospital patient does not complete the application form within 30 days of delivery, AHS will notify the patient that the application has not been received and will provide the patient an additional 120 days to complete the application. If the application form is subsequently submitted it will be accepted.
4. The patient must make every reasonable effort to furnish the hospital with documentation of income. The documentation requirements are on the charity budget form.

The patient must attest in writing that the information they are furnishing to the hospital is accurate.

b. Charity Presumptive Eligibility

AHS understands that certain patients may be unable to complete a Financial Assistance application, comply with requests for documentation, or are otherwise non-responsive to the application process. As a result, there may be circumstances under which a patient’s qualification for Financial Assistance may be established without completing the formal assistance application and/or providing the necessary and required documents for approval. AHS may utilize other sources of information to make an individual assessment of financial need to determine whether the patient is eligible for financial assistance and approval. This information will enable AHS 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. In particular, presumptive eligibility for Financial Assistance may be determined on the basis of individual life circumstances that may include:

- Homelessness or receipt of care from a homeless clinic;
- Participation in Women, Infants and Children (WIC) programs;
- Eligibility for food stamps;
- Eligibility for school lunch programs;
- Living in low-income or subsidized housing; and
- Patient is deceased with no estate.

c. Homeless Patients:

Emergency room patients without a payment source may be classified as charity if they do not have a job, mailing address, residence, including temporary residence, or insurance. However, all other county, state, or government programs must be considered as part of enrollment screening. Consideration must also be given to classifying emergency-room-only patients who do not provide adequate information as to their financial status. In many instances, these patients are homeless and have few resources to cover the cost of their care.

For homeless patients seen in our inpatient or emergency services areas, AHS must ensure financial screening is provided to the patient prior to discharge. This includes but is not limited to screening for charity care.

d. Special Circumstances

1. Deceased patients without an estate or third party coverage may be eligible for charity.
2. Patients who are in bankruptcy (filed but an open case) or completed bankruptcy in the past three (3) months may be eligible for charity.

e. Time Requirement for Determination of Eligibility

1. While it is desirable to determine the amount of charity care for which a patient is eligible as close to the time of service as possible, in some cases, eligibility is readily apparent and a determination can be made before, on, or soon after the date of service. In other cases, it can take investigation to determine eligibility, particularly when the patient has limited ability or willingness to provide needed information. At any time, if a patient sends confirming information and the application that demonstrate qualification for charity care, then charity care will be indicated. AHS will make every effort to provide a determination of eligibility within 30 days of receiving all requested information and documentation from the patient.
2. Every effort should be made to determine a patient's eligibility for charity care. In some cases, a patient eligible for charity care may not have been identified prior to initiating external collection action. Accordingly, any collection agency will be made aware of the policy on charity care. This will allow the agency to refer patient accounts back to AHS that may be eligible for Charity Care.
3. After 150 days of no response from a patient to formally determine eligibility the account may proceed to debt collection. If the patient was initially identified as probable charity care and the staff has no public or private record to locate the patient (e.g., homeless with no residence) the case may be classified as charity care. The Director of Patient Financial Services will use appropriate judgment to differentiate charity care based on the criteria in lieu of a bad debt determination.
 - a. Denials and Appeals

Application Denied

No financial assistance is granted under this policy. However, if patient is self-pay, the patient may be eligible according to the prompt pay discount policy.

Appeals

In the event of a dispute over the application of this policy, a patient may seek review from AHS Director of Patient Access Services or Director of Patient Financial Services. The patient may also follow the hospital's complaint policy. The patient will be informed of any decision in writing

4. Contracting with Other Organizations to Determine Eligibility

AHS may from time to time contract with other organizations that specialize in assisting patients and their families with qualifying for charity or other sources of funding or insurance enrollment. Organizations (Contractors) are required to abide by the policies set forth by AHS. Patients are given information regarding the availability of assistance from these other organizations and are encouraged to cooperate with the qualifying process. Patients are not expected to incur any costs when utilizing the services of these other organizations.

5. Eligibility Period:

The eligibility period is up to six months from the date of the initial eligibility determination, unless over the course of that period the patient's Family Income or insurance status changes to such an extent that the patient becomes ineligible. This discount may be applied retroactively for up to six months if there were unavoidable delays in determining eligibility.

II. Limiting Expected Reimbursement

A. General Rule

The maximum payment amount for patients who qualify for charity care or a discounted payment, who do not have insurance coverage, shall be the full in effect allowable Medicare rate fee schedule for the service (s) as calculated in accordance with Medicare payment rules. [H&S §127405(d)]

For any patient who has coverage under a third party insurance plan, that third party insurance contract shall establish the payment rate. If the insured patient qualifies for charity care then the patient's portion of the payment (Copayment) shall be waived.

Please note that "[n]o health care service plan, insurer, or any other person shall reduce the amount it would otherwise reimburse a claim for hospital services because a hospital has waived, or will waive, collection of all or a portion of a patient's bill for hospital services in accordance with the hospital's charity care or discount payment policy, notwithstanding any contractual provision." [H&S § 127444]

B. Medi-Cal Denied Patient Days and Non-Covered Services

Medi-Cal/CCS and other State of California programs patients are eligible for Charity care write-offs related to denied stays in limited circumstances (e.g., when the admission/services were medically necessary as determined by the treating physician or the patient was not safe to discharge and there is no administrative day payment). The Treatment Authorization Request (TAR) will record the reason for the denial. An example where the write-off is charity is when a Medi-Cal pending application results in a denial as not eligible as a result of not meeting program guidelines. Denials for other reasons such as a physician's failure to write a discharge order cannot be written off as charity care. Recognizing that the hospital is compensated by Medi-Cal on a per case basis, there will be limited circumstances where a charity care write-off will apply.

III. Limited Debt Collections Activities

A. Notice Prior to Commencing Collection Activities

The hospital or any assignee of a hospital debt, including a collection agency must provide the patient with a clear and conspicuous notice that includes the required language from the various practice acts and a statement that nonprofit credit counseling services may be available in the area.

B. Collection Practices

The hospital and the patient may negotiate the terms of the payment plan. The hospital will not charge interest on the extended payment plan debt. An extended payment plan may be re-negotiated with the patient if the patient fails to make all consecutive payments during a 90-day period. Prior to declaring an extended payment plan irremediable the patient must be:

- a. Contacted or attempted to be contacted by telephone (last known number);
- b. Given notice in writing that the plan may be irremediable (last known address); and
- c. Informed that there is an opportunity to re-negotiate the payment plan.

C. Advancing Debt and Credit Reporting

Until the payment plan is declared irremediable, no report may be made to a consumer credit reporting agency and no civil action may commence. Any advancing of debt for collection or reporting requires the approval of the Director of Patient Financial Services. Advancing of debt collection and/or Credit reporting shall not occur until after 150 days from the date the payment plan is declared irremediable.

D. Collection Agency

If a collection agency identifies a patient meeting AHS charity care eligibility criteria, the patient account may be considered charity care, even if they were originally classified for collection or as a bad debt. Collection agency patient accounts meeting charity care criteria should be returned to the AHS billing office and reviewed for charity care eligibility.

IV. Charity Care Information- Notice

A. Patient Intake Process

Except in the case of emergency services, Alameda Health System shall provide patients with information regarding charity care, during the patient intake process, if requested. AHS shall also provide patients with contact information for an AHS employee or office from which the patient may obtain further information about charity care and discount payments. The information provided shall be in the primary language of AHS service area and in a manner consistent with all applicable federal and state laws and regulations. A language is a primary language of Alameda Health System service area if 5% or more of Alameda Health System local population speaks the language.

B. Public Notice and Posting of Charity Care

Public notice of the availability of assistance through this policy should be made through each of the following means: Posting notices in a visible manner in locations where there is a high volume of inpatient or outpatient admitting/registration. Notices must be posted in at least the emergency departments, billing offices, admitting offices, and hospital outpatient service settings. Posted notices shall contain the following information:

1. A statement indicating that AHS has a financial assistance policy for low-income uninsured patients who may not be able to pay their bill and that this policy provides for full or partial charity care.
2. Identification of a hospital contact phone number that the patient can call to obtain more information about the policy and how to apply for assistance.

C. Bills and Statements

AHS shall include charity care information on bills and statements sent to patients. The information shall include following:

1. If the patient meets certain income requirements the patient may be eligible for a government-sponsored program or qualify for charity care or discount payment from AHS. The income requirements shall be stated on the notice.
2. A hospital phone number that patients may call for further information.
3. Posting notice of the availability of assistance and a contact phone number on AHS web site.
4. Providing uninsured patients a document outlining the types of financial assistance available.

D. Emergency Physicians Billing Notice (applicable at Alameda Hospital and San Leandro Hospital)*

AHS shall include a notice with the contact information for independent Emergency Physicians that practice at Alameda Hospital and San Leandro Hospital. These independent physician groups have their own discount policies with eligibility criteria which may differ from AHS policies. Emergency physicians are not required to offer an extended payment plan; but if they do, the plan must be interest free. AHS includes in the notice the name of the physician group, the web site, and a contact phone number the patient may call for additional information. Emergency Physicians are the Emergency Physician specialists staffing the emergency department of the hospital.

Emergency Physicians are not other specialists who consult in the emergency department by request of the Emergency Physician. [H&S §127450-127462]

V. Reimbursing Overcharges

If the hospital erroneously collected the patient portion, from a patient who qualifies for charity care, the patient will be reimbursed the principle. This clause shall not apply if the overpayment is \$5 or less. In this case, the hospital shall furnish credit equal to the amount of \$5 or under for a period of 60 days.

VI. Not Available for Charity Care

Charity care and/or discounts provided by this policy are not available for cosmetic procedures. The application of this policy does not apply to any portion of a patient's services because of the transfer of a patient to another facility that bill for services under a different Tax Identification Number. The hospital will make every effort to locate a charitable organization that AHS is aware of or has a relationship with to furnish elective procedures.

VII. Authority and Responsibilities

A. Authority

Authority for decision making with regard to this policy and the progression to formal debt collection is granted to the Director for Patient Accounting and Patient Access Services and/or an individual with such authority at a higher level or rank in the hospital including the Vice President of Revenue Cycle, the Chief Financial Officer and other personnel granted this authority for coverage when the Director or designee is not available.

B. Responsibilities

Who Can Grant Charity Care Write-offs:

Director of Patient Financial Services, Director of Patient Access Services or their designee

C. Roles and Responsibilities:

Procedures must be adopted that clearly address the various responsibilities in the determination of charity care. This includes documentation of any contact with the patient, provision of information, and assistance to the patient making the determination of charity care eligibility, and notifying the patient.

D. Record keeping:

Records relating to potential charity care patients must be readily accessible. AHS must maintain information regarding the number of uninsured patients who have received service, the number of financial assistance applications completed, the number approved, the estimated dollar value of the benefits provided, the number denied, and the reasons for denial.

In addition, notes relating to charity application and approval or denial should be entered on the patient's account

VIII. Submission to OSHPD

Beginning January 1, 2008, and biennially thereafter (every two years) by January 1, AHS shall forward copies of this policy to the Office of Statewide Health Planning and Development (OSHPD). Submission of the policy shall be consistent with the manner prescribed by OSHPD.

Who Can Grant Charity Care Write-offs:

Director of Patient Financial Services, Director of Patient Access Services or their designee

Accounting for Charity Care:

To allow AHS to track and monitor the amount and type of charity care being granted, the hospital will account for the charity care write-offs and record all transactions as an “administrative write-off.”

Roles and Responsibilities:

Procedures must be adopted that clearly address the various responsibilities in the determination of charity care. This includes documentation of any contact with the patient, provision of information, and assistance to the patient making the determination of charity care eligibility, and notifying the patient.

Record keeping:

Records relating to potential charity care patients must be readily accessible. AHS must maintain information regarding the number of uninsured patients who have received service, the number of financial assistance applications completed, the number approved, the estimated dollar value of the benefits provided, the number denied, and the reasons for denial.

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ATTACHMENTS

- **Attachment A:** Charity Care Application
- **Attachment B:** Notification Status

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Department	Date:	N/A	03/2020	03/2020
Pharmacy and Therapeutics (P&T)	Date:	N/A	N/A	N/A
Clinical Practice Council (CPC)	Date:	04/2020	N/A	N/A
Medical Executive Committee	Date:	N/A	04/2020	04/2020
Board of Trustees	Date:		N/A	N/A