Sliding Fee Discount Policy & Procedure – FQHC and Other

Effective Date	Not Set	***Date Revised***	05/26/2021
Document Owner	VP, REVENUE CYCLE	***Next Scheduled Review***	05/26/2024
Executive Responsible	Not Assigned		

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

PURPOSE

The purpose of this policy is to define the eligibility criteria for the Sliding Fee Discount Program (SFDP) and to minimize financial barriers to care for AHS patients at or below 200% of the Federal Poverty Level (FPL).

POLICY

Alameda Health System (AHS) will operate in a manner such that no patient shall be denied care due to an individual's inability to pay. Alameda Health Systems (AHS) maintains a standard procedure to qualify patients for Sliding Fee Discount Program (SFDP) for services provided. Sliding Fee Discounts are available to patients with all incomes at or below 200% of the Federal Poverty Level (FPL). Sliding Fee Discount 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 Sliding Fee Discount and other programs during the patient intake process. Patients (and/ or representatives) are expected to cooperate with AHS to determine Sliding Fee Discount 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 Sliding Fee Discount are in concert with our mission and our community obligations.

AHS Patients who do not have third-party insurance and are not eligible for government program will receive a self-pay discount off AHS charges. The self-pay uninsured discount percentage is 50%.

SCOPE

This Policy applies to the FQHC Sites and those other Sites and Services listed in the Health Resources and Services Administration (HRSA) scope of work.

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 – the** family includes the patient's spouse, registered domestic partner and dependent children under 21 years of age.
b) **Patients under 18 years of age – the** 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.

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 Sliding Fee Discount patients.

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. Also includes a patient whose benefits under all potential sources of payment have been exhausted prior to admission.

Self -Pay Discount: Describes the situation where the hospital has determined that the patient does not qualify for Sliding Fee Discount but is eligible for a self-pay discount and is expected to pay only a part of the bill.

High Medical Costs: Is a person whose family income does not exceed 350 percent of the FPL percent if that individual does not receive a discounted rate from the hospital because of his or her third party coverage.

Financially Qualified Patient: A patient who is both of the following: A patient who is a self-pay patient, or a patient with high medical costs. And a patient who has a family income that does not exceed 350 percent of the federal poverty level.

PROCEDURES

Eligibility

Sliding Fee Discount will be applied for those individuals according to the Sliding Fee Schedule.

Sliding Fee Schedule is as follows:

Sliding Fee Scale Category	Partial Discount/ Amount Charged
At or below 100% of the FPL	No Charge
101-133% of the FPL	$1.00
134-166%	$2.00
167-200%	$3.00

For patients that are above 200% and up to 350% of the FPL, AHS will offer a partial discount amount charged of $4.00. This discount is not under FQHC funding and AHS will utilize other funding sources to provide this discount. The Fee Schedule can be found on our website under Price Transparency: http://www.alamedahealthsystem.org/patients-visitors/

All medical services are inclusive except services that use an outside provider in which AHS does not bill for. For services within AHS for which this policy does not apply, the patient does not need a new application but will fall under the hospital Charity Care policy.

Eligibility will be determined in accordance with the following procedures to ensure an individual assessment of Family Income. The application process will require the following information from the patient:

- Completed signed application
- Proof of Income Tax return and monetary assets or subsequent month bank statements or most recent payroll stub or FICA earnings summary from SSA.

In determining whether an individual qualifies for Sliding Fee Discount, 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.

AHS shall assist patients in exploring appropriate alternative sources of payment and coverage from public and private payment programs and to also assist patients in applying for such programs. However, if the patient applies, or has a pending application for another health coverage program at the same time that he or she applies for a hospital Sliding Fee Discount or discount payment program, neither application shall preclude eligibility for the other program.

Medi-Cal patients who are responsible to pay share of cost are not eligible to apply for Financial Assistance to reduce the amount of Share of Cost owed. AHS shall seek to collect these amounts from the patient.

Patients whose income exceeds 350% of the FPL may be eligible to receive discounts based on AHS Discount policy.

Insured patients with high medical costs or limited coverage who have exhausted their benefit coverage may qualify for Sliding Fee Discount.

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 cash, checking accounts, savings accounts, money market funds, certificates of deposits, real estate property, etc.

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.

Homeless Patients:

Patients without a payment source may be classified as eligible 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 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 AHS must ensure financial screening is provided. This includes but is not limited to screening for Sliding Fee Discount.

Determination of Eligibility

While it is desirable to determine the amount of Sliding Fee Discount 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 Sliding Fee Discount, then Sliding Fee Discount 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.

Every effort should be made to determine a patient's eligibility for Sliding Fee Discount. In some cases, a patient eligible for Sliding Fee Discount may not have been identified prior to initiating external collection action. Accordingly, any collection agency will be made aware of the policy on Sliding Fee Discount. (See Debt Collection and Collection Agency management policy). This will allow the agency to refer patient accounts back to AHS that may be eligible for Sliding Fee Discount.

The granting of the Sliding Fee Discount shall be based on an individualized determination of Family Income, and shall not consider age, gender, race, social or immigrant status, sexual orientation, or religious affiliation.

Discounts will be based on family size and total household income only.

Disputes

A patient may seek review of any decision by the Hospital to deny Sliding Fee Discount by notifying the Director of Patient Financial Services or the Director of Patient Access.

Uninsured discounts and Extended Payment Plans

AHS patients who do not have third party insurance and are not eligible for a government program will receive a discount off AHS charges. The uninsured discount percentage for Hospital and Professional billing is 50% from total charges

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. The extended payment plan may be declared no longer operative after the patient's failure to make all consecutive payments 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 renegotiated payment plan. After a payment plan is declared inoperative, AHS or the contracted collection agency may commence collection activities. (See Debt Collection and Collection Agency management policy).

Sliding Fee Discount Application

Application

1. A low-income uninsured patient who indicates the financial inability to pay a bill for a medically necessary service shall be evaluated for Sliding Fee Discount assistance or any other federal, state, or county program.

2. The AHS standardized application form, shown as the "Sliding Fee Discount Application" (see Attachment B), 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 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 AHS with documentation of income. The documentation requirements are on the charity budget form.

5. Self-declaration of income may be used when the patient is homeless with no job, paid in cash, or does not have the means to obtain written proof of income. Patients who are unable to provide written verification must provide a signed statement of income, and why they are unable to provide independent verification. The statement will be presented to the financial counselors for review and final determination as to the sliding fee percentage.

Eligibility Period:
Once the determination is made that the patient is eligible for Financial Assistance and Sliding Fee Discount patients will be eligible for a period of one year after the determination is made. After one year, patients must re-apply for Financial Assistance and Sliding Fee Discount. If at any time information relevant to the eligibility of the patient changes, it is the patient's responsibility to notify AHS of the updated information.

A review will include any other outstanding accounts for the patient that may also be eligible for the financial assistance approval timeframe.

Sliding Fee Discount Information- Notice

Patient Intake Process

Alameda Health System shall provide patients with information regarding Sliding Fee Discount, during the patient intake process. AHS shall also provide patients with contact information for an AHS employee or office from which the patient may obtain further information about Sliding

Fee Discount 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.

Public Notice and Posting of Sliding Fee Discount

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 ambulatory clinic locations. 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 a Sliding Fee Discount.
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.

Bills and Statements

AHS shall include notice on all bills and statements sent to patients notifying patients of the availability of financial assistance. The information shall include following:

1. Phone number for patients to call with questions about financial assistance
2. The website address where patients can obtain additional information about financial assistance including the financial assistance policy and a plain language summary of the policy and the application for financial assistance.

Reimbursing Overcharges

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

Not Available for Sliding Fee Discount

Sliding Fee Discount 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.

I. 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 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 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 Sliding Fee Discount application and approval or denial should be entered on the patient's account

II. 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.

ATTACHMENTS

- Attachment A: Sliding Fee Scale
- Attachment B: Sliding Fee Discount Application
- Attachment C: Determination Letter

Approvals

Director, Patient Financial	**Date: 04/2021**
Director, Patient Access	**Date: 04/2021**
Chief Financial Officer	**Date: 04/2021**
VP Revenue Cycle	**Date: 04/2021**
AHS Homeless Health Center Co-Applicant Board	**Date:**
Office of the General Counsel	

04/09/2021

TO: **Health Care for the Homeless Center Co-Applicant Board**

FROM: **Heather MacDonald Fine, Practice Manager**

SUBJECT: **Agenda Item: F**

Meeting Date: **04/13/2021**

Item Description: **Approval of the Sliding Fee Discount Policy and Procedure**

BOARD ACTION: Approve the Sliding Fee Discount Policy and Procedure

Background

As a Health Resources and Services Administration (HRSA) Health Center, our Health Center must operate in a manner such that no patient is denied services due to an individual's inability to pay. Consistent with this commitment, Health Centers must prepare a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation and must prepare a corresponding schedule of discounts [sliding fee discount schedule (SFDS)] to be applied to the payment of such fees or payments, by which discounts are adjusted on the basis of the patient's ability to pay. Among several other things, Health Centers' are required to establish a functional system for [sliding fee] eligibility determination. Previously, AHS used a charity care policy for the system. To improve care for patients, it was determined that in the Ambulatory Care setting, a Sliding Fee Discount Policy would reduce the financial burden on patients seen in the Ambulatory Care setting.

Analysis

Alameda Health System (AHS) has developed Sliding Fee Discount Policy and Procedure that meets HRSA requirements and ensures that no patient is denied services due to his or her inability to pay.

Prior Board Action: Approved Charity Care Policy 1/14/2020

Board Action Requested: Approval of the Sliding Fee Discount Policy and Procedure

Fiscal Impact: n/a

Budgeted/Authorized: Yes

Estimated Cost Savings: n/a

Federal Poverty Guidelines with Sliding Fee Schedule
2021 Annual and Monthly Thresholds
Attachment A

Family Size	Poverty Guideline 100% of the FPL		100% WRITE OFF	101-133% of the FPL		Partial Discount	134-166% of the FPL		Partial Discount	167-199% of the FPL		Partial Discount	Ineligible 201% and above
	Annual Income	Monthly Income	Fee	Annual Income	Monthly Income	Fee	Annual Income	Monthly Income	Fee	Annual Income	Monthly Income	Fee	
1	$12,880	$1,073	No Charge	$17,130	$1,428	$1	$21,381	$1,782	$2	$25,631	$2,136	$3	
2	$17,420	$1,452	No Charge	$23,169	$1,931	$1	$28,917	$2,410	$2	$34,666	$2,889	$3	
3	$21,960	$1,830	No Charge	$29,207	$2,434	$1	$36,454	$3,038	$2	$43,700	$3,642	$3	
4	$26,500	$2,208	No Charge	$35,245	$2,937	$1	$43,990	$3,666	$2	$52,735	$4,395	$3	
5	$31,040	$2,587	No Charge	$41,283	$3,440	$1	$51,526	$4,294	$2	$61,770	$5,147	$3	
6	$35,580	$2,965	No Charge	$47,321	$3,943	$1	$59,063	$4,922	$2	$70,804	$5,900	$3	
7	$40,120	$3,343	No Charge	$53,360	$4,447	$1	$66,599	$5,550	$2	$79,839	$6,653	$3	
8	$44,660	$3,722	No Charge	$59,398	$4,950	$1	$74,136	$6,178	$2	$88,873	$7,406	$3	

For families/households with more than 8 persons, add $4,540 for each additional person

Partial discounts are provided for individuals and families with incomes above 100% of the current FPG and at or below 200% of the current FPG, and those discounts adjust based on gradations in income levels and include at least three discount pay classes.

ALAMEDA HEALTH SYSTEM

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APPLICATION FOR DISCOUNT SERVICES SLIDING FEE SCHEDULE

The data gathered on this form will only be used to get information about you and your family so that we can better meet your medical or behavioral health needs. **This information will not be used to withhold or deny services to you**.

Patient Information		
Name:	Telephone Number:	
Address:		
City:	State:	Zip:
Applicant (Guarantor) Information	□ *If same as above check this box and proceed to question #1.*	
Relationship to patient: □ Self □ Parent/Guardian		
Name:		Date of birth:
SSN:	Telephone Number:	
Address:		
City:	State:	Zip:

1. Are you covered under Medi-Cal, Medicare and/or any other insurance?	□ Yes □ No
2. If you have private insurance, what is your out of pocket expense?	$_____
3. Have you or your family ever applied for or been denied for Medi-Cal or Medicare?	□ Yes □ No
4. Would you like to apply or re-apply for Medi-Cal today?	□ Yes □ No
5. Are you unemployed?	□ Yes □ No
6. Are you too sick to work or are you disabled?	□ Yes □ No

Please include yourself, your spouse/partner and all dependents under 21 years of age living in the home below:

Name	Date of Birth	Relationship to Head of House	Insurance or Medi-Cal?
		Head of Household	**Yes or No**
			Yes or No
			Yes or No
			Yes or No
			Yes or No
			Yes or No

If additional dependent fields are needed, please document on page X

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INCOME VERIFICATION

Please enter your **gross income** (the amount received before taxes are taken out). Household income includes ***everyone*** in the home. **Proof of income includes:** most recent tax return, check stubs, a letter from the employer stating wages earned, perjury statement or proof of unemployment.

If there is **no income to report**, please bypass the income table and proceed to the next step.

HOW ARE YOU PAID? AMOUNT? CIRCLE ONE?

Employment Income	**$**	**Weekly /Bi weekly /Other Part Time / Full Time**	***Office Use Only*** □ Income Verified FPL: _____ □ Identification Verified **Staff Signature**:_____ **Date**: _____ **Patient Advised of Discount Rate: _____** Staff Initials **Enrollment Dates:_____to_____** **Approved By**:_____ **Date**: _____ **PLEASE REFER TO THE CURRENT AHS SLIDING FEE DISCOUNT SLIDE SCHEDULE*
Cash Income	**$**	**Weekly /Bi weekly /Other**	
Disability	**$**	**Weekly /Bi weekly /Other**	
Social Security	**$**	**Weekly /Bi weekly /Other**	
Unemployment	**$**	**Weekly /Bi weekly /Other**	
Worker's Comp	**$**	**Weekly /Bi weekly /Other**	
Child Support	**$**	**Weekly /Bi weekly /Other**	
Other Income	**$**	**Weekly /Bi weekly /Other**	

PATIENT ACKNOWLEDGEMENT STATEMENT

I certify that the information provided is accurate and complete to the best of my knowledge and in the event of a change in income or insurance coverage, I will contact/notify the facility. I understand that I will be financially responsible for **all or a portion of my care** and that I will be asked to **submit payment at the time of service**. I authorize the release of any information necessary to establish my eligibility for discounted services and I give my consent to release my information to Pharmaceutical Companies for auditing purposes only for any Bulk Medication Patient Assistance Programs of which I may enrolled.

Patient Signature_____ Date_____

ALAMEDA HEALTH SYSTEM

Insert Label Box here

Declination Statement (for Patient's Who Do Not Want to Comply with Sliding Scale Requirements)

Because you do not wish to apply for our sliding scale discount, you are choosing to be a self-pay patient. This means that you will be responsible for any and all balances due after the self-pay discount. Office and lab charges are not applicable, and you will not be allowed to receive a discount for these charges.

Patient Signature_____ Date_____

COMPLETE BELOW FOR Self-Declaration of Income

Please complete the information below only ***if you have no other way to document your income***. All of the boxes below must be checked, and all the questions answered. Failure to complete this information will result in a denial of your application for a sliding scale discount.

- ☐ I get paid in cash.
- ☐ I do not get pay checks/pay stubs.
- ☐ I cannot get a letter from my employer. Explain why: _____
- ☐ I do not have access to my financial information, Explain why: _____

Patient Certification Statement

☐

I certify that I have no other way to document my income and that all of the above information is accurate. I understand that this information is to be used to determine eligibility for the AHS Sliding Fee Discount Schedule. I understand that AHS officials may verify information on this form.

Patient Signature_____ Date_____

Employee Certification Statement

I certify that I asked the applicant/recipient about all the sources of income received by the household and, before using this form, used best efforts to obtain other possible sources of documentation. The information reported on this form was provided solely by the applicant/recipient and reflects the income the applicant reported to me.

Employee Signature_____ Date _____

ALAMEDA HEALTH SYSTEM

SLIDING FEE DISCOUNT DETERMINATION LETTER

Date

Guarantor:
Address:

Re: Eligibility Determination for Sliding Fee Discount Program

Dear:_____:

Alameda Health System (AHS) has conducted an eligibility determination for the Sliding Fee Discount Program:

_____	_____	_____
Patient's Name	Medical Record Number	Enrollment Period

Based on the information supplied by the patient or on behalf of the patient, the following determination has been made:

☐ Your request for the SFDP has been approved for services provided during the enrollment period identified above.

Your out of pocket cost for each ambulatory visit is:_____ (Insert patient shared cost)

☐ Your request is pending approval. However, the following information is required before any adjustment can be applied to your account:

_____

☐ Your request has been denied because:

☐ Income level exceed guidelines
☐ We didn't receive required documentation for review/approval

Please call us if you have any questions or need additional information

Thank you

_____	_____
Eligibility Specialist	Phone Number

Revised 03/2021