SAN FRANCISCO HEALTH NETWORK
CHARITY CARE AND DISCOUNT PAYMENT PROGRAM
POLICY AND PROCEDURE

Patient Financial Services Department	
Reviewers: Thomas Istvan, Director Patient Financial Services Tim Arnold, Director Patient Accounting Henry Lifton, Deputy City Attorney Jenine Smith, Senior Manager Patient Financial Services	**Original Date:** December 14, 2006 **Revision dates:** March 8, 2007, September 12, 2007, December 14, 2007, June 22, 2008, June 1, 2009, July 15, 2009, April 1, 2011, April 1, 2012, April 1, 2014, January 1, 2015, July 15, 2016, December 1, 2017, August 3, 2019, January 1, 2023, January 1, 2024, May 22, 2024, **January 1, 2025**

I. Purpose

The purpose of this policy is to define the Charity Care and Discount Payment Programs' financial assistance guidelines and eligibility for the San Francisco Health Network (SFHN) consistent with the provisions of Assembly Bill (AB) AB774, AB1020, AB532, and 2297, and Senate Bill (SB) SB1276.

II. Policy

It is the policy of the SFHN to comply with all federal, state, and local regulations to provide financial assistance of the Charity Care and Discount Payment Programs to qualified uninsured and underinsured patients who have participated in a screening for Medi-Cal and may have been determined ineligible for federal, state, and county programs with a payment responsibility for services received. If any regulation, current or future, conflicts with this policy, the regulation will supersede this policy.

III. Scope

This policy covers Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG), Specialty Outpatient Clinics, Community Primary Care Clinics, Laguna Honda Hospital and Rehabilitation Center, Behavioral Health Services, and the Population Health Division of the San Francisco Department of Public Health (SFDPH). This policy applies to services that do not qualify for other discount packages or programs such as the Hospital's maternity package, abortion services package or other package programs that are provided to patients at a global rate with significant discounts below government rates and are not subject to additional discounts. All accounts with patient liability will be considered.

This policy does not apply to emergency, inpatient, radiology, and procedure room physician fees, which are billed by and covered in the policy and procedure of UCSF Clinical Practice Group, Business Services/dba SFGH Medical Group. An emergency physician, as defined in California Health & Safety Code Section 127450, who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or

patients with high medical costs who are at or below 400% of the Federal Poverty Level.

IV. History

A. Effective January 1, 2007 for ZSFG patients, and September 17, 2007 for Community Primary Care (COPC) patients, SFHN made available the Charity Care and Discount Payment Programs to assist uninsured or underinsured patients with limited income of up to 350 percent Federal Poverty Level (FPL) and who are not eligible for the Sliding Scale Program, government programs, or other payers including third party liability.

B. Effective November 1, 2010, SFHN made available the Catastrophic High Medical Expense Program to assist uninsured or underinsured patients who are ineligible for Sliding Scale, Charity Care or Discount Payment Programs with medical expenses exceeding 120 percent of their household annual income and who are not eligible for the Charity Care and Discount Payment Programs, Sliding Scale Program, government programs, or other payers including payments they might receive because of third party liability.

C. Effective January 1, 2015, ZSFG amended this policy per SB1276 legislation providing that:

1. The definition of a person with high medical costs includes those persons who do receive a discounted rate from the hospital as a result of third- party coverage.

2. The hospital shall negotiate with a patient regarding a payment plan, taking into consideration the patient's family income and essential living expenses.

3. The hospital shall determine a reasonable payment formula where monthly payments are not more than 10 percent of a patient's family income, excluding deductions for essential living expenses.

4. If the hospital and the patient cannot agree to a payment plan, the hospital shall use the specified formula of deducting 60% for essential living expenses from patient's gross household income and then calculate 10% of the remaining income to determine a reasonable monthly payment amount. The hospital provides patients with a referral for assistance to the Health Consumer Alliance at (888) 804-3536 or The Health Consumer Center/Bay Area Legal Aid at (855) 693-7285.

D. Effective August 3, 2019, this policy was amended in accordance with the City and County of San Francisco's (City) Health Commission Resolution No. 19-8, which resulted in the following changes:

1. The Charity Care Program qualifying FPL was increased to 500 percent.

2. The Discount Payment Program qualifying FPL was changed to include all FPL levels.

3. The high medical cost qualifying criteria was eliminated.

4. The Catastrophic High Medical Expense program was eliminated.

E. Effective January 1, 2023 this policy will be amended in accordance with AB1020: Health Care Debt and Fair Billing and AB532: Fair Billing Policies.

F. Effective May 22, 2024, this policy will include Specialty Mental Health and Substance Use Disorder outpatient services through Behavioral Health Services.

G. Effective January 1, 2025, this policy is amended per AB2297 legislation.

V. DEFINITIONS

A. **Allowance for financially qualified patient** means, with respect to services rendered to a financially qualified patient, an allowance that is applied after the Hospital's charges are imposed on the patient, due to the patient's determined financial inability to pay the charges.

B. **Charity care** means free care.

C. **Discounted payment** or **discount payment** means any charge for care that is reduced but not free.

D. **Financial Assistance** means to provide charity care or discounted payment to financially qualified patients.

E. **Financially Qualified Patient** means an uninsured or underinsured patient with payment liability/responsibility who meets the Charity Care or Discount Payment program's eligibility criteria.

F. **Federal poverty level (FPL)** means the measure of income as issued annually by the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. FPL is based on a patient's family size and income and used by hospitals to determine financial assistance eligibility.

G. **Hospital** means ZSFG, Specialty Outpatient Clinics, Community Primary Care Clinics, Laguna Honda Hospital and Rehabilitation Center, the Population Heath Division of SFDPH, and Behavioral Health Services.

H. **Patient** refers to the person for whom services were rendered.

I. **Guarantor** means a person who has legal financial responsibility for the patient's health care services.

J. **Patient's Family** means the following:

1. For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not.

2. For persons under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker relatives, and parent's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not.

K. **Self-pay** means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the Hospital. Self-pay patients may include charity care patients**.**

L. Uninsured means a patient who has no third-party source of payment for any portion of the patient's medical expenses, including without limitation, commercial or other private insurance, government-sponsored healthcare benefit programs, or third-party liability and includes a patient whose benefits under all potential sources of payment have been exhausted prior to an admission or rendered service.

M. **Underinsured** means a patient who has a third-party source of payment for a portion of the patient's medical expenses with the remaining portion applied to the patient's responsibility/liability. This excludes patients who are covered by Medi-Cal/Medicaid.

VI. HEALTH CARE COVERAGE ASSISTANCE AND FINANCIAL ASSISTANCE NOTICES

A. The Hospital's policy for providing financial assistance to qualified self-pay patients is available to patients through the following ways.

1. Notices are clearly and conspicuously posted in locations that are visible to the public in the ZSFG emergency room waiting room, urgent care waiting room, outpatient waiting rooms, the ZSFG Hospital main lobby, and the Behavioral Health Access Center lobby. It is also posted on the Hospital website at https://www.zuckerbergsanfranciscogeneral.org/services/financial-assistance/ with the Charity Care and Discount Payment program application available to download.

    1. Financial Assistance Policies and Applications (English) are uploaded biennially beginning 01/01/2024 to the HCAI Hospital Fair Billing Program HCAI website located at: https://hcai.ca.gov/affordability/hospital-fair-billing-program/hospital-fair-pricing-policy-lookup/.
    2. The submitter of these policies is duly authorized to submit such policies.
    3. The submitted policies are true and correct copies of the Hospital's policies.

2. Written notices will be provided at the time of service in the Terms and Conditions of Admission for episodic admissions, in the ZSFG Patient Guidebook provided to patients admitted as inpatient, in the Behavioral Health Beneficiary Handbook, and as a patient handout in outpatient clinics will include the following information:

i. Internet address of the Health Consumer Alliance (https://healthconsumer.org) and a statement that there are organizations that will help the patient understand the billing and payment process.
ii. Information about Covered California.
iii. Information about Medi-Cal presumptive eligibility if the Hospital participates in the presumptive eligibility program.
iv. Internet address for the Hospital's list of shoppable services, as required by federal law.

B. Patients' MyChart electronic health portal provides information about financial assistance, preliminary screening tool and allows patients to send a message in the portal to the Patient Financial Services Department to request financial assistance.

C. Patient billing statements include information for:

1. Obtaining billing assistance.
2. Requesting an itemized bill.
3. Requesting health care application assistance.
4. Requesting financial assistance. The final patient billing statement will also include a Charity Care and Discount Payment program application.
5. Contacting Health Consumer Alliance https://healthconsumer.org/ (888) 804-3536, Bay Area Legal Aid https://baylegal.org/ (855) 693-7285.
6. Overdue accounts are assigned to the Bureau of Delinquent Revenue (BDR) in the Office of the Treasurer and Tax Collector.

VII. HEALTH CARE COVERAGE ASSISTANCE PROGRAMS

A. Patient Access collects patient demographic, financial and insurance information to determine if the patient has insurance to cover the services, is uninsured or underinsured with only partial coverage. Patient Access will refer uninsured or underinsured patients to schedule an appointment with the ZSFG or BHS Patient Access Enrollment Department or financial counselor located in the clinic which services are being provided, if available.

B. Patient Access provides uninsured and underinsured patients with healthcare coverage screening and application assistance depending on the program or package for which the patient is determined preliminarily eligible.

C. Programs and packages may include but are not limited to the following:

1. AIDS Drug Assistance Program (ADAP)
2. Breast and Cervical Cancer Treatment Program (BCCTP)
3. California Children's Services
4. California Victim Compensation Program
5. Children's Presumptive Eligibility and Newborn Gateway Programs
6. Covered California
7. Every Woman Counts, Breast and Cervical Cancer Detection program
8. Family Planning Access, Care and Treatment Program
9. Medi-Cal, which provides free or low-cost health insurance to eligible California residents with limited income
10. Hospital Presumptive Eligibility Medi-Cal Program, which provides immediate access to temporary, no-cost Medi-Cal services while individuals apply for permanent Medi-Cal
11. Healthy San Francisco Program
12. OB Package Program for prenatal care and delivery at ZSFG.
13. Department of Public Health County Indigent Sliding Scale Program
14. Presumptive Eligibility Medi-Cal for Pregnant Women
15. VIP Package Program for pregnancy termination.

D. A patient may contact the ZSFG or BHS Patient Financial Assistance Department to apply for the financial assistance programs, which may waive or reduce the patient's self-pay payment responsibility.

VIII. FINANCIAL ASSISTANCE PROGRAMS

A. The Charity Care Program and Discount Payment Program are available to patients with a self-pay payment responsibility if they participate and cooperate with a required Medi-Cal screening, and required pursuit and exhaustion of insurance and third-party liability, including but not limited to the following:

1. A patient or guarantor must comply with pursuing and communicating with any commercial or employer sponsored insurance plans for payment of their services, including cooperation with the appeals process and requests for information.

2. A patient or guarantor must pursue all potential third-party liability, and worker's compensation claim and provide notice of any settlement payment.

3. A patient must comply with participating in an eligibility screening and counseling for Medi-Cal.

4. A patient or guarantor who receives payment directly from their insurance or other third-party payer for services rendered by the San Francisco Health Network are required to relinquish those payments in full to the ZSFG or BHS Patient Accounting Department, whichever is applicable.

5. A patient or guarantor who receives a legal settlement, judgment, or award under a liable third-party action that includes payment for health care services or medical care related to the injury, must reimburse the Hospital for the related health care services rendered up to the amount reasonably awarded for that purpose.

B. The Hospital's maternity OB package, VIP abortion services package, or other package programs that are provided to patients at a global rate with significant discounts below government rates fall under the Discount Payment policy and are not subject to additional discounts.

C. These are not subject to additional discounts.

IX. CHARITY CARE PROGRAM ELIGIBILITY

A. Charity Care Program eligibility is based on income.

B. A patient's household income may not exceed 138% of the Federal poverty level.

C. Charity Care eligibility requires full cooperation with program requirements to pursue and exhaust insurance and third-party liability.

D. Charity Care eligibility waives a patient's self-pay liability.

X. DISCOUNT PAYMENT PROGRAM ELIGIBILITY

A. Discount Payment Program eligibility is based on income.

B. A patient's household income may be at or above 139% of the Federal poverty level. There is no federal poverty level limit for a patient to qualify. The patient's federal poverty level determines the amount of the discount.

C. Discount Payment eligibility requires full cooperation with program requirements to pursue and exhaust insurance and third-party liability.

D. Discount Payment program eligibility reduces a patient's self-pay liability.

XI. FINANCIAL ASSISTANCE APPLICATION

1. Patients may apply for the Charity Care Program and Discount Payment Program in one single application.

2. A patient or guarantor must provide one completed application with the required verification, from which eligibility will be determined.

3. Patients should make every effort to complete an application within 12 months from the date of service to expedite financial assistance determination with full cooperation of all program requirements.

4. Application assistance is available by contacting the applicable department:

   i. Calling ZSFG Patient Financial Assistance Department at (628) 206-3275; Monday –Friday 8:00am – 11:30am and 1:00pm – 5:00pm.

   ii. Calling BHS Member Services Department at (888) 246-3333.

   iii. Sending a message in the request financial assistance section of the patient's MyChart patient portal account.

B. Applications must be mailed to the department address:

1. Applications for ZSFG must be mailed to Zuckerberg San Francisco General Hospital Patient Financial Assistance Department 1001 Potrero Ave., Building 20, San Francisco, CA 94110.

2. Applications for BHS must be mailed to BHS Member Services Department, 1360 Mission St., 2nd Fl, San Francisco, CA 94103.

XII. INCOME VERIFICATION

A. The Charity Care Program or Discount Payment Program require income verification with the application.

B. Patients must provide the most recent three (3) months of pay stubs prior to date of application or most recent year income tax return for all qualified household members.

C. Patients unable to provide the most recent three (3) months of pay stubs prior to date of application or most recent year income tax return may offer another type of income verification for review.

D. Patients unable to provide income verification will be screened for presumptive eligibility based on meeting one of the following criteria:

1. Patients with a housing status of homeless

2. Patients having an estimated federal poverty level of the patient's household income from electronic soft credit inquiry.

E. Patients with active county or state program insurance or coverage that does not cover the dates of service being billed to them, may have their income verification substituted as follows to qualify for a financial assistance program.

1. Patients confirmed with active Medi-Cal may replace the income verification with current eligibility in the Medi-Cal program.

2. Patients confirmed with active Healthy San Francisco may replace the income verification with current enrollment with Healthy San Francisco.

3. Patients confirmed with active with a County Medical Services Program (CMSP) may replace the income with current eligibility in the CMSP program.

4. Patients confirmed with active Medicaid out of state may replace the income verification with current eligibility in the Medi-Cal program.

F. The Hospital shall not use the information provided by patients to verify income eligibility for collections activities.

XIII. FINANCIAL ASSISTANCE APPLICATION STATUS

A. Upon determination of a patient's eligibility for the Discount Payment or Charity Care Programs, the patient will receive a letter that includes the following information:

1. A clear statement of the Hospital's determination of the patient's eligibility for the Discount Payment and/or Charity Care Programs.

2. If the patient was denied eligibility for either program, a clear statement explaining why the patient was denied the discount payment, charity care, or both.

3. If the patient was approved for discount payment or charity care, a clear explanation of the reduced bill and instructions on how the patient may obtain additional information regarding a reasonable payment plan, if applicable.

4. The name of the Hospital office, contact name, and contact information where the patient may appeal the Hospital's decision.

5. Information regarding the Hospital Bill Complaint Program.

6. Information on the Health Consumer Alliance.

B. Application Approved

1. Patients will receive written notification of approval with the final amount of their payment responsibility after the approved discount has been applied.

2. Approval for the Discount Payment Program will be billed the discounted payment amount for the dates of service applicable to the application.

3. Approvals for the Charity Care Program will have a no payment responsibility and will no longer be billed for the dates of service applicable to the application.

C. Application Denied

1. Patients will receive written notification of a denial with the denial reason.

2. Patients will continue to be billed for their payment responsibility

3. Patients can reapply.

D. Application Closed as Inactive

1. Patients will be notified if their application is incomplete or missing verification and will be provided 30 calendar days to complete.

2. Applications that remain incomplete for more than 30 calendar days will be closed in an inactive status until the patient contacts the department to reopen the application with complete information and verification.

3. Patients will continue to be billed for their payment responsibility.

XIV. APPEALS PROCESS

A. Patients may request an appeal of their Charity Care or Discount Payment program eligibility decision in writing with the reason for appeal and supporting verification to support the appeal reason within 15 business days of receiving an application decision.

B. Appeals for ZSFG billed services must be mailed to:
Zuckerberg San Francisco General Hospital
1001 Potrero Ave., Ward 15
San Francisco, CA 94110
Attention: Jenine Smith, Patient Financial Services Senior Manager

C. Appeals for BHS billed services must be mailed to:
BHS Member Services Department
1360 Mission St., 2nd Floor
San Francisco, CA 94103

D. Appeals and supporting verification will be reviewed per each program's eligibility requirements. Additional information and/or verification may be required.

E. Patients will be notified in writing of the appeal decision.

XV. PATIENT CAP

A. In addition to offering a Charity Care Program and Discount Payment Program, DPH also applies a Patient Cap for certain patients. The Patient Cap reduces self-pay patient liability without an application or action from a patient or guarantor.

B. The Patient Cap is a predetermined maximum amount that a patient is held liable for outpatient and inpatient accounts. It is applied based on system rules that determine if the patient and account qualify. When patients and their accounts qualify, a system adjustment is applied that reduces the balance to the Patient Cap amount.

C. Patients and accounts that are excluded from and do not qualify for the Patient Cap continue with the full account balance as their self-pay liability. The following are excluded from the Patient Cap.

1. Patients who do not reside in the United States.
2. Accounts that are covered by workers compensation or third-party liability.

3. Accounts which have been assigned to the Bureau of Delinquent Revenue.
4. Accounts that are eligible for the OB package or VIP package.
5. Patients and guarantors who have received a direct payment from their insurance for their medical services and have not surrendered the payment to the San Francisco Health Network.
6. Accounts that have been outsourced to the DPH contractor for Uncompensated Care Recovery Services.

XVI. PAYMENT PLANS

A. Payment plans are available with ZSFG Patient Accounting Customer Service Department, the BHS Member Services Department, or the City & County of San Francisco Office of the Treasurer & Tax Collector Bureau of Delinquent Revenue (BDR) depending on which entity the account is with and the terms of the payment plan.

B. Patients may request a payment plan from ZSFG Patient Accounting Department or the BHS Member Services Department if the account(s) have not been assigned to BDR and the payment plan meet the acceptable monthly payment amount and length of time.

C. Patients may create their own payment plan in their MyChart patient portal.

D. Patients may receive assistance with creating a payment plan.

1. Payment plans for ZSFG billed services may be requested or renegotiated through any of the following method:
2. Send a message in their MyChart patient portal account
3. Email SFHNPatientFinancialServices@sfdph.org for ZSFG billed services.
4. Call (628) 206-8448 Monday – Friday 8:00am – 11:30am and 1:00pm – 5:00pm for ZSFG billed services.

2. Payment plans for BHS billed services may be requested or renegotiated through any of the following method:

1. Send a message in their MyChart patient portal account
2. Email BHSMemberServices@sfdph.org for BHS services.
3. Call (888) 246-3333 for BHS services.

E. Patients with delinquent payment plans will receive billing statements notifying them of the delinquent payments and to make a payment to bring their account current.

F. Patients who request a payment plan initially or through renegotiation that exceed the parameters will have their accounts assigned to the BDR for payment plan assistance. Refer to City & County of San Francisco Office of the Treasurer & Tax Collector Bureau of Delinquent Revenue Zuckerberg San Francisco General Hospital Debt Collection Policies and Procedures.

REFERENCES:

- Assembly Bill 2297 Hospital and Emergency Physician Fair Pricing Policies.
- Assembly Bill 1020: Health Care Debt and Fair Billing 2022

- Assembly Bill 532 Health Care Fair Billing Policies 2021
- UCSF Clinical Practice Group, Business Services/dba SFGH Medical Group Guarantor/AB1020 Policy and Procedure
- City & County of San Francisco Office of the Treasurer & Tax Collector Bureau of Delinquent Revenue Zuckerberg San Francisco General Hospital Debt Collection Policies and Procedures
- Senate Bill 1276 Health care: fair billing policies 2014
- Assembly Bill 774 Hospitals: fair pricing policies 2007