April 11, 2016

District Board Meeting

Packet Addendum

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: April 11, 2016

To: City of Alameda Health Care District, Board of Directors

From: Kristen Thorson, District Clerk

Subject: February 8, 2016 Draft Minutes

Attached are the Minutes of the February 8, 2016 Board meeting for your review.

I recommend deferring the acceptance of the minutes on the Consent Calendar to allow sufficient time for the Board to review and comment on the minutes.

CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the City of Alameda Health Care District Board of Directors
Open Session
Monday, February 8, 2016 Regular Meeting

Board Members Present		Legal Counsel Present	Excused / Absent
Robert Deutsch, MD Tracy Jensen Jim Meyers, DrPH	Kathryn Sáenz Duke Michael Williams	Thomas Driscoll, Esq.	
Submitted by: Kristen Thorson, District Clerk			

Topic		Discussion	Action / Follow-Up
I.	Call to Order	The meeting was called to order at 5:37 p.m.	
II.	Roll Call	Kristen Thorson called roll, noting a quorum of Directors was present.	
III.	General Public Comments	No public comments.	
IV.	Regular Agenda		
	A. Alameda Health System and Alameda Hospital Updates		
	1) AHS quarterly Reporting – Finance and Quality • December 2015 AHS Financials • FY15-16 Parcel Tax Expenditures Update David Cox, CFO for Alameda Health System, presented a financial update including an update on managed care contracting strategy and parcel tax expenditures as outlined in the PowerPoint presentation. Director Deutsch and Director Jensen expressed concern about the contracting strategy and the potential loss of volume due to the strategy. Pertaining to the AHS contracting strategy and contracting issues at Alameda Hospital and AHS, Director Jensen requested follow-up on the impact at the next meeting, including impact on surgeries, census and other utilization of hospital services by payor as well as looking at historical volumes. Ms. Panlasigui indicated that she would be able to provide some statistical information. Director Deutsch requested additional information on the parcel tax expenditures and specifically the allocation of funds for the District Clerk. He requested further follow-up from		

Topic	Discussion	Action / Follow-Up
	AHS at the next meeting. Director Meyers requested a copy of the AHS Charity Care Policy. Mr. Cox said that he would provide to the Board. Copies of the presentation will be available from the clerk and posted on the website. • Quality Dashboard Kern Bashaw, RN VP of Quality for Alameda Health System, reviewed the quality dashboard and noted that a Joint Commission mock survey was completed at Alameda Hospital in anticipation of the triennial survey. 2) Status of Long Term Capital Fund Mr. Cox stated that they are looking at the mechanisms to meet the intent of the JPA and establishment of the long term capital fund. 3) AHS Follow-up on Request for Additional Information on Support Services Allocation Methodology Mr. Cox addressed the support services methodology in his report. 4) Alameda Hospital CAO Report Bonnie Panlasigui distributed and reviewed a memorandum recapping a year end reflection for 2015 highlighting accomplishments from Alameda Hospital and Alameda Health System. Director Jensen provided an Board of Trustee (BOT) update noting that the 2nd Wednesday of the month the AHS BOT will have education session and the 4th Thursday will be the regular business meeting of the BOT. She distributed organization charts for the System and Alameda Hospital as information. She also noted that the Highland new tower project is near completion and recently had a grand opening ceremony. She stated that this project is the largest public works project in Alameda County history.	
B.	Consent Agenda	
	1) Acceptance of November 9, 2015 Minutes 2) Acceptance of January 18, 2016 Minutes On the January 18, 2016 minutes, Director Sáenz Duke requested that additional information be added to Section III. General Public Comments, after the last sentence. "He briefly reviewed some of the many changes he has seen in Alameda Hospital during those years. He congratulated the Board for recognizing that the hospital could not continue independently and then taking on the significant step of affiliating with Alameda Health System."	Director Jensen moved and Director Sáenz Duke seconded to accept the consent agenda with changes noted. The motion carried with one abstention (Meyers).

Topic	Discussion	Action / Follow-Up
	C. Action Items	
	1) Acceptance of FYE June 30, 2015 Audit	Director Jensen moved and Director Williams seconded to accept the FYE June 30, 2015 Audit. The motion carried.
	2) Election of Officers Director Meyers nominated Director Sáenz Duke to office of President, Director Jensen seconded, and nomination accepted by Director Sáenz Duke. Director Sáenz Duke nominated Director Deutsch to the office of 1st Vice President, to which the nomination was declined by Director Deutsch. Director Deutsch nominated Director Jensen to office of 1st Vice President, Director Sáenz Duke seconded, and nomination was accepted. Director Sáenz Duke nominated Director Meyers to the office of 2nd Vice President, Director Jensen seconded, and nomination accepted by Director Meyers. Director Jensen nominated Director Williams to office of Secretary, Director Sáenz Duke seconded, and the nomination was accepted by Director Meyers. Director Deutsch nominated himself to office of Treasurer, Director Jensen seconded. Director Jensen nominated herself to the office of Alameda Health System Liaison, Director Sáenz Duke seconded. Director Sáenz Duke nominated Director Meyers to the office Community Health Liaison, Director Williams seconded, and nomination was accepted by Director Meyers. Director Jensen nominated Director Deutsch to the office of Alameda Hospital Liaison, Director Sáenz Duke seconded and nomination was accepted by Director Deutsch.	Director Jensen moved and Director Williams seconded to elect the slate of officers as outlined below. The motion carried. Office President – Kathryn Sáenz Duke 1st Vice President – Tracy Jensen 2nd Vice President – Jim Meyers, DPh Secretary – Michael Williams Treasurer – Robert Deutsch, MD Alameda Health System Liaison – Tracy Jensen Community Health Liaison – Jim Meyers, DPh Alameda Hospital Liaison – Robert Deutsch, MD
	3) Review and Approval of Engagement Letter with CHW, LLP for Accounting and Business Services	Director Jensen moved and Director Sáenz Duke seconded to approve entering into a new engagement with CHW, LLP for accounting and business services. The motion carried.
	4) Selection of Executive Director Search Committee and Review of Proposed Charter There was discussion regarding the memo on selection of an ad hoc committee to begin the process of selecting an Executive Director. The Board agreed that the ad hoc committee	The Board agreed to appoint Director Sáenz Duke and Director Williams to the ad hoc committee for

Topic	Discussion	Action / Follow-Up
	come back to the April 11, 2016 Board meeting with proposals from 2-3 firms to help with the search for an Executive Director.	the Executive Director Search Committee.
	5) Acceptance of December 2015 District Financials Due to the accidental non-inclusion of the financial statements in the packet addendum, the acceptance of the December Financials was deferred to the next meeting.	No action taken
	6) Approval to Renew General and Excess Liability Insurance for Jaber Properties	Director Sáenz Duke made a motion to renew general and excess liability insurance policies for the Jaber properties at a cost not to exceed $5,143 with the renewal year of March 2016 - March 2017 and Director Jensen seconded. The motion carried.
	7) ACSDA Annual Meeting Attendance and/or Sponsorship	The Board agreed to try and send one Director and the District Clerk to the annual meeting and dinner.
C.	District Updates & Operational Updates	
	1) Final Approved Bylaws The approved bylaws were provided as reference.	No action taken.
	2) April 11, 2016 Board Agenda Preview a) Brown Act Presentation b) Review and Approval of FY 2016-2017 District Budget c) Review and Approval of AHS FY 2016-2017 Parcel Tax Budget d) Acceptance of February 8, 2016 Minutes e) Alameda Hospital CAO Report In addition, Alameda Health System and David Cox has committed to presenting updates to the Board regarding contracting and other system updates.	No action taken.
	3) Report on Alameda County Special District Association Meetings No verbal report provided.	No action taken.

Topic	Discussion	Action / Follow-Up
V.	**General Public Comments** None	No action taken.
VI.	**Board Comments** None	No action taken.
VII.	**Adjournment** Being no further business the meeting was adjourned at 7:41 p.m.	

Attest:

Kathryn Sáenz Duke
President

Michael Williams
Secretary

	Alameda Health District - Fiscal 2016 Budget Recommendation	Fiscal 2015 Budget	Fiscal 2016 Budget	Fiscal 2017 Proposed
1	**Estimated parcel tax receipts**	**$ 5,784,199**	**$ 6,003,078**	**$ 5,957,818**
2				
3	District budget allocation	613,527	397,630	536,998
4	Repayment of loan plus accrued interest	1,598,438	-	-
5	Repayment of AH Foundation Loan	405,000	-	-
6	Facilities Projects	231,038	2,870,000	1,000,000
7	Capital Equipment	1,000,000	2,000,000	1,000,000
8	Accounts Payable Reduction	1,936,197	-	-
9	Seismic Retrofit	-	-	2,967,700
10	Long Term Capital Reserve	-	735,449	453,121
11	Operating Support	-	-	-
12	**Total Uses of Parcel Tax**	**$ 5,784,199**	**$ 6,003,078**	**$ 5,957,818**
		$ -	$ -	$ -

Total Uses of Parcel Tax	$ 5,784,199	$ 6,003,078	$ 5,957,818
District budget allocation	(613,527)	(397,630)	(536,998)
Balance to transfer to Alameda Health System	$ 5,170,672	$ 5,605,448	$ 5,420,820

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: April 11, 2016

To: City of Alameda Health Care District, Board of Directors

From: Kristen Thorson, District Clerk

Subject: Follow-Up from 4/11/16 District Board Meeting – AHS

The following policies were requested from Alameda Health System at the February 8, 2016 District Board Meeting. These policies were provided by the System and distributed to the Board via email on March 23, 2016.

These policies are being distributed to the Board for reference at the meeting on April 11, 2016 and as part of the public record.

Alameda Health System

Charity Care/Financial Assistance Policy

Department	Patient Access and Financial Services	Origination By	April Bass
Unit	Patient Access and Financial Service	Origination Date	March 2004
Manual	Patient Access Services	Date Reviewed	July 2015
Function	Charity Care Program Screening	Date Revised	July 2015
		Next Scheduled Review	July 2018

PURPOSE

The purpose of this policy is to define the eligibility criteria for charity care assistance and provide administrative guidelines for the identification and classification of Alameda Health System (AHS) patient accounts as charity care.

The procedure describes the process to identify and secure all available third party coverage and government programs, and to make the Charity Care and Discount Payment Programs and reasonable payment plan available to self-pay or high medical cost patients as defined in AB774 and SB1276.

It is the intent of this policy to comply with all federal, state, and local regulations. If any regulations, current or future, conflicts with this policy, the regulation will supersede this policy.

POLICY STATEMENT

It is the policy of AHS to provide charity care to patients according to the guidelines of this policy. Charity care is defined as health care services provided at no charge or at reduced charge to patients who do not have or cannot obtain adequate financial resources or other means to pay for their care. This is in contrast to a bad debt which is defined as a patient and/or guarantor who, having the requisite financial resources to pay for health care services, has demonstrated by their actions an unwillingness to resolve the bill. Partial and full charity care will be based solely on ability to pay and will not be abridged on the basis of age, sex, race, creed, disability or national origin. Classification of healthcare services as charity care can occur at any time and will be determined based on the eligibility requirements identified in Section III of this policy. Included in this policy are medical services that are provided by AHS facilities, all enrolled and/or employed providers of AHS. AHS will administer this policy within the scope of California state law and regulations including, but not limited to, AB 774, SB 1276, and AB 1503.

Charity care will not be made for non-medically necessary services (cosmetic surgery, patient convenience hospital days and services, etc.). Patients will remain financially responsible and be billed for these services.

Charity is not considered to be a substitute for personal responsibility. Patients and individuals representing the patient are expected to cooperate with AHS to determine charity eligibility and to contribute to the cost of their care based on their individual ability to pay. In cases where the patient has either not requested charity assistance or has not timely provided AHS with information to determine charity eligibility, AHS will continue routine processing through the collection cycle (collection statements, telephone calls, collection agency assignment, etc.).

In order to effectively manage limited resources and to provide the appropriate level of assistance to the greatest number of persons in need, AHS establishes the following guidelines for the provision of patient charity.

The Charity Care Discount Payment Program (See Discount Policy) is available to assist uninsured or underinsured patients with limited income of up to 350 Federal Poverty Level (FPL) and who are not eligible for the Sliding Scale Program, government programs, or other payers including third party liability.

Per Senate Bill No. 1276 (SB1276), legislation provides:

- 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 3rd party coverage
- The hospital shall negotiate with a patient regarding a payment plan, taking into consideration the patient's family income and essential living expenses
- 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
- 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

DEFINITIONS

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

Charity Care: Healthcare services that have or will be provided but are not expected to result in cash collections. Charity care results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

Family: Using Internal Revenue Service rules, if the patient or guarantor (spouse, legal guardian) claims someone as a dependent on their income tax return, they may be considered a dependent for the purposes of the provision of financial assistance.

Family Income: Using the Census Bureau definition, family income includes the following income sources on a before tax basis when computing the federal poverty guidelines:

- Earnings from employment, unemployment compensation, worker's compensation, Social Security, SSI, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, and other miscellaneous sources.

- Does not include noncash benefits (such as food stamps and housing subsidies) and capital gains or losses.

Uninsured: The patient has no level of insurance coverage or third party assistance to assist with meeting his/her payment obligations.

Underinsured: The patient has some level of insurance coverage or third party assistance but has out-of-pocket expenses that exceed his/her financial abilities.

A. A patient's qualifying assets must not exceed $250.00 at the time of service, as defined in AB 774. (According to AB774, the first ten thousand ($10,000.00) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent 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

that is an income generating property or is not the primary residence, annuities; stock; bond or mutual funds that are not part of a retirement or deferred compensation plan qualified under the Internal Revenue Code, or non-qualified deferred-compensation plan.).

B. Patient has 30 days from receipt of application to provide all required information on other coverage, including pursing third party liability.

1. Patient must apply for government programs for which he or she is potentially eligible. Patient's who do not cooperate will not be eligible.

2. Patient must complete an application and provide required verifications as follows:

    a. Most recent 3 months of patient's pay stubs from date of the Charity application or last income tax return. Income on last tax return is divided by 12 months to identify the monthly income.
    b. Last 3 months of bank or brokerage account statements from date of Charity application.
    c. Applicants enrolled and active with Health PAC (HPAC) may replace item (a) and item (b) with current eligibility in the HPAC program. Applicant qualifies for Charity care.

3. Patient's with income level at 0% to 200%, 201% to 275% , or 275%.01 to 350% of the FPL will receive varying Charity Care discounts referenced in Section III of this policy (refer to discount grid).

4. Patients who decline to provide asset information will be evaluated only for Discount Payment Program.

5. Services that are part of a package program are provided at a discounted rate and are not eligible for the Charity Care or the Discount Program.

C. Requirements for Patients with High Medical Costs:

1. Patients with High Medical Costs must meet the Charity requirements and also meet one of the following conditions to receive Charity Care.

    a. Annual out of pocket costs incurred by the individual at the hospital must exceed 110 percent of the patient's family income in the prior 12 months.

    b. Annual out of pocket expenses that exceed 110 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

    c. **Patients who do receive a discounted rate from the hospital as a result of 3rd party coverage.**

    d. Patient must meet Charity Care criteria for qualifying assets.

ELIGIBILITY

The following categories of patient accounts and patients will be classified for charity care:

Category A – Charity Application Process. Patients in this category must complete the attached application form with proof of income and their family income must fall within the financial criteria to receive full or partial charity care (see Attachment A). Families whose income exceeds the income criteria may still qualify for charity care with a cost share (see Attachment B). This category includes patients who do not qualify for Medi-Cal and other assistance programs but may be financially unable to pay all or part of the hospital bill. This category includes individuals and families who may fall between the "eligibility cracks" of the available medical assistance programs. Individuals and families may be partially covered by health insurance and seek charity care assistance for out-of-pocket amounts.

Category B – Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file due to a lack of supporting documentation or other reasons. Often there is adequate information provided by the patient or through other sources, which provides sufficient evidence to provide the patient with charity care assistance. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

1. Deceased patients with no known estate
2. Homeless or resides in a homeless shelter
3. Collection agency or attorney assigned accounts that are now determined indigent, including bankruptcy.
4. Current Medi-Cal or other medical assistance qualified patients that request charity for prior months services which were not covered retroactively.
5. Patients with "out of state" Medi-Cal coverage of which AHS is not an approved provider.
6. Other indigent life circumstances situations.

AHS will attempt to verify all other coverage means prior to enrollment.

PROCEDURAL GUIDELINES

STEP 1. Charity Application Process (Only for Category A)
The AHS employee processing the charity request should secure a completed charity application and at least one form of proof of income (most recent W-2, check stubs for last 3 pay periods, signed letter from employer confirming income, etc.) The AHS employee must complete the Eligibility Calculation Form and determine the level of charity assistance by using the family size and income information that was included on the charity application.

STEP 2 – Confirm and Document Facts (All Categories)
The AHS employee who initiates a request for charity care should thoroughly research and document in the patient account notes all relevant facts. In addition, the patient account notes and all applicable documentation should be forwarded through the levels of management to the lowest level able to authorize the write-off amount (see write-off matrix below).

STEP 3 – Review and Eligibility Determination (All Categories)
Authorized employees must review the account notes and the applicable documents to assure that information is complete and reasonable efforts have been made to secure other sources of payment. If additional information is needed before eligibility can be determined, the charity request is forwarded to the appropriate AHS employee for follow up. Once eligibility is determined the authorized employee must state approval or denial and the reason for the determination in the account notes, plus in any other applicable document (s), such as the Eligibility Determination Notice (which is then sent to the patient).

STEP 4 – Adjustment of Balance and Follow up (All Categories)
The documents should then be returned to the AHS employee to process the write-off for those patients that are approved for charity. All accounts with a remaining patient responsibility balance will be placed back into the normal collection follow up work flow.

The patient account financial history and the charity care documents are to be archived for no less than five years. These records are to be archived in such a manner as to assure easy accessibility.

Departmental	Date: CFO, Feb. 8, 2016
General Counsel	Date:
Medical Executive Committee	Date:
Board of Trustees	Date:

ATTACHMENT A *(must be completed for all Category A cases)*

Alameda Health System

CHARITY CARE PROGRAM APPLICATION

DATE OF REQUEST_____

PATIENT'S NAME: _____TELEPHONE:_____

ADDRESS :_____(street)

_____(city, state, zip code)

MARTIAL STATUS: _____ SOC SEC #: __ __ __-__ __-__ __ __ __

ACCOUNT #:_____DATE(S) OF SERVICE: _____

DO YOU HAVE OTHER HEALTH INSURANCE? YES_____ NO_____ (If YES, need copy of card)

NAME OF SPOUSE OR GUARNTOR: _____

ALL SOURCE(S) OF INCOME: _____

PATIENT'S EMPLOYER: _____ LAST DAY WORKED: _____

SPOUSE'S EMPLOYER: _____ LAST DAY WORKED: _____

GROSS ANNUAL FAMILY INCOME (include proof of income such as: check stubs, W-2 forms, income tax returns, etc.):

SELF: $_____ PROVIDER OF FINANCIAL INFORMATION (If other than patient or guarantor):
SPOUSE: $_____
OTHER: $_____
TOTAL: $_____

NAME: _____

ADDRESS: _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT IS SUBJECT TO VERIFICATION BY AHS AND SUBJECT TO REVIEW BY GOVERNMENTAL AGENCIES.

REQUESTED BY: _____

DO NOT COMPLETE (To be completed by Hospital Personnel only.)

This document was received on: _____By:_____
(Name & Title)

ATTACHMENT B *(form must be completed for Category A cases to determine eligibility)*

CHARITY CARE PROGRAM
ELIGIBILITY CALCULATION

PATIENT NAME: _____

ACCT(S) #:_____

TOTAL PATIENT BALANCES OF ALL ACCOUNTS: $_____

GROSS ANNUAL FAMILY INCOME $_____

FAMILY SIZE_____

INCOME QUALIFIES FOR WRITE-OFF OF _____%

WRITE-OFF AMOUNT $_____

SLIDING FEE DISCOUNT SCHEDULE Effective July 1, 2015												
Category	**A**		**B**		**C**		**D**		**E**		**F**	
% Federal Poverty Limit (FPL)	100% and under		101-133%		134-167%		168-200%		200.01-275%		275.01-350%	
% Discount	100%		100%		100%		100%		75%		60%	
Nominal/ Flat Fee												
Income Range for Each Category by Family Size												
Family Size	From	To	From	To	From	To	From	To	From	To	From	To
1	$0	$11,770	$11,771	$15,654	$15,655	$19,656	$19,657	$23,540	$23,541	$29,425	$29,426	$35,310
2	$0	$15,930	$15,931	$21,187	$21,188	$26,603	$26,604	$31,860	$31,861	$39,825	$39,826	$47,790
3	$0	**$20,090**	**$20,091**	**$26,720**	**$26,721**	**$33,550**	**$33.551**	**$40,180**	**$40,181**	**$50,225**	**$50,226**	**$60,270**
4	$0	**$24,250**	**$24,251**	**$32,253**	**$32,254**	**$40,498**	**$40,499**	**$48,500**	**$48,501**	**$60,625**	**$60,626**	**$72,750**
5	$0	**$28,410**	**$28,411**	**$37,785**	**$37,786**	**$47,445**	**$47,446**	**$56,820**	**$56,821**	**$71,025**	**$71,026**	**$85,230**
6	$0	**$32,570**	**$32,571**	**$43,318**	**$43,319**	**$54,392**	**$54,393**	**$65,140**	**$65,141**	**$81,425**	**$81,426**	**$97,710**
7	$0	**36,730**	**$36,731**	**$48,851**	**$48,852**	**$61,339**	**$61,340**	**$73,460**	**$73,461**	**$91,825**	**$91,826**	**$110,190**
8	$0	**$40,890**	**$40,891**	**$54,384**	**$54,385**	**$68,286**	**$68,287**	**$81,780**	**$81,781**	**$102,225**	**$102,226**	**$122,670**

Liability 0%: No co-payment
Liability 25%; ER 25%; IP 25%; OP 25%; RX $5; SP 25%
Liability 40%; ER 40%; IP 40%; OP 40%; RX $5; SP 40%
*Income above 350%, see Private Pay Discount Policy

Name of submitting AHS employee: _____

Approved By: _____ Date: _____

ATTACHMENT C *(form letter to be used to notify responsible party of eligibility decision)*

Date

Guarantor Name
Address Line 1
Address Line 2
Address Line 3

Re: Eligibility Determination for Charity Care Program

Dear: *Guarantor Name:*

AHS has conducted an eligibility determination for the Charity Care Program for:

_____ _____ _____
PATIENT'S NAME ACCOUNT NUMBER DATES(S) OF SERVICE

BALANCE $_____

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

____Your request for the Charity Care has been approved with a cost share of $_____. Please pay the cost share amount within 30 days or contact the below hospital business office representative to discuss possible payment options.

____ Your request for the Charity Care is pending approval. However, the following information is required before any adjustment can be applied to your account:
_____
_____

____ Your request for the Charity Care has been denied because:

_____

Please pay the above patient responsibility amount within 30 days or contact the below hospital business office representative to discuss possible payment options.

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

Thank you.

_____
Business Office /Eligibility Specialist

Non-Participating Prompt-Pay Discount Policy

Department	Patient Access	Origination By	L. Sander
Unit		Origination Date	September 2015
Manual	Patient Financial Services	Date Reviewed	
Function		Date Revised	January 2016
		Next Scheduled Review	September 2018

PURPOSE:

The purpose of this policy is to document Alameda Health System's Non-Participating Prompt Pay Discount program in order to identify and reduce patient's out-of-pocket expense if they pay their portion timely. Alameda Health System recognizes the significant burden placed on individuals and wishes to facilitate the prompt payment of patient financial obligations when AHS is non-participating with an insurance plan or program. In addition, Alameda Health System must satisfy the requirements for the Medical Center's participation in specific governmental supplemental programs and adhere to the requirements of Senate Bill No. 1276 (enacted September 28, 2014) which is addressed under a separate policy.

POLICY:

It is the vision of Alameda Health System to maintain and improve the health of Alameda Health System community and to be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimizes the health of our diverse communities. It is the policy of Alameda Health System to offer Prompt Pay discounts to patients with insurance coverage when AHS is non-participating. This policy applies to a Preferred Provider Organization benefit plan (PPO) or Point of Service benefit plan (POS) plan the insurance is not contracted with Alameda Health System (i.e. AHS is a "non-participating provider"). The patient's out of pocket expense for covered services at AHS will be discounted to the estimated out of pocket expense that the patient would have owed if the patient had received the same or similar services at a Participating Provider with the patient's insurance plan, when paid within a specified prompt pay timeframe.

The discounts will be recorded as a "Non-Participating Prompt Pay Discount" in the financial billing and reporting systems.

Upon final adjudication by the insurance company of a claim, if the original estimate was calculated to be higher based on the estimated variables (e.g. expected services, number of days, billed charges) than the actual patient responsible portion, AHS shall refund any overpayment.

This policy is written within the parameters stated by the State and Federal regulations or opinions referenced below. This policy may be subject to change as a result of new state and federal legislation or opinions. All revisions will be approved by the appropriate oversight department, committee or applicable body.

Discount policies for Self-Pay and Uninsured Charity Care are separate and address AHS patient payment obligations when financial means meet qualifications.

Non-Participating Prompt-Pay Discount Policy

PROCEDURE:

Discounts:

Type	Definition	Discount Rate	Comments and Tracking Code
Non-Participating Status	Patients with a POS or PPO plan that includes a Non-Participating benefit AND AHS is NOT a participating provider. Requires payment in full up to a six (6) month period. THIS OPTION DOES NOT APPLY WHEN THE INSURANCE PLAN DOES NOT INCLUDE A BENEFIT FOR PAYMENT WHEN SERVCIES OCCUR AT A NON-PARTICIPATING FACILITY (HMO, EPO)	Calculate the difference between in-plan provider benefit and non-participating provider benefit based on the Allowed Amount using the "Calculator". When the Allowed Amount is known, include the Allowed Amount in the "Calculator". When the Allowed Amount is not known, default to 50% of Billed Charges. The discount to be considered is the difference between the in-plan vs. out-of-network patient responsibility (copayments and deductibles).	Discount to be applied: "Non-Participating Prompt Pay Discount" when patient signs Prompt Pay Agreement. If the patient defaults on the agreement (payment not received in full as per signed agreement), then the Non-Participating Prompt Pay Discount will be reversed and patient billed at the full insurance amount due.

Non-Participating Prompt-Pay Discount Policy

Guidelines:

1. **Documentation** - Patients must make reasonable effort to provide AHS with documentation of insurance coverage. All patients entering into a discount under this policy MUST COMPLETE AND SIGN THE PROMPT PAY PATIENT AGREEMENT. When the Prompt Pay Discount applies, the system must be documented with appropriate notes and amounts with reference to the e-file for the actual agreement and calculator worksheet.

2. **Negotiation** - AHS and the patient can negotiate the terms of the prompt **payment plan** (not the financial amount due) not to exceed a six month time period. If AHS and the patient cannot agree on a payment plan, or the patient cannot meet the six month payment requirement, then AHS will not offer the Participating/Non-Participating prompt pay discount.

3. **Reimbursement** - Reimbursement is expected in accordance with the discount amounts.

4. **Extended Payment** - The prompt pay component of this policy cannot be extended.

5. **Voided Payment Plans** - The reimbursement plan can be declared no longer valid if a patient fails to make payment according to the written discount agreement. Before declaring a payment plan to be invalid, AHS will make a reasonable attempt to contact the patient by telephone (to last known number) to collect amount due. The hospital or collection agency will not report adverse credit information regarding the patient or take civil action against the patient for nonpayment prior to declaring the payment plan no longer valid.

6. **Subsequent Patient Qualification for Financial Assistance Policy**. If a patient who has entered into a Discount Agreement subsequently qualifies for the Financial Assistance Policy, then the Financial Assistance Policy shall replace the Discount Agreement in its entirety.

Patients qualify for a self-pay discount at the time of service or related recurring services. This discount may be applied retroactively if there were unavoidable delays in determining eligibility or patient cost sharing amounts with the appropriate level approval.

References:

California Business & Professions Code 657
OIG Opinion No. 08-03 Issued January 30, 2008

Attachment: Calculation Worksheet
Prompt Pay Patient Agreement