University of California
Patient Financial Services Department
POLICIES AND PROCEDURES

Title: Charity Care Policy	Policy #: 114.3
Effective Date: Revised March 2011	Page 1 of 14

I. PURPOSE

The University of California, Irvine Medical Center (Medical Center) strives to provide quality patient care and high standards for the community we serve. This policy demonstrates the Medical Center's commitment to our mission and vision by helping to meet the needs of the low income, uninsured patients and the underinsured patients in our community. This policy is not intended to waive or alter any contractual provisions or rates negotiated by and between a Medical Center and a third party payer, nor is the policy intended to provide discounts to a non-contracted third party payer or other entities that are legally responsible to make payment on behalf of a beneficiary, covered person or insured.

This policy is intended to comply with California Health & Safety Code section 127400 *et seq. (AB 774)*, Hospital Fair Pricing Policies, as revised by SB 350 (Chapter 347, Statutes of 2007) effective January 1, 2008, and Office of Inspector General, Department of Health and Human Services ("OIG") guidance regarding financial assistance to uninsured and underinsured patients. Additionally, this policy provides guidelines for identifying and handling patients who may qualify for financial assistance. This policy also establishes the financial screening criteria to determine which patients qualify for Charity Care. The financial screening criteria provided for in this policy are based primarily on the Federal Poverty Level (FPL) guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services. Uninsured patients who do not meet the criteria for Charity Care under this policy may be referred to the Uninsured Discount Policy.

II. SETTING

Hospital inpatient and outpatient departments. Emergency room physician fees are included under a separate policy. All other physician fees are excluded.

III. POLICY

A. This policy is designed to provide assistance to Financially Qualified Patients, who require medically necessary services, are uninsured, ineligible for third party assistance or have high medical cost. Patients are granted assistance from unfunded charity, State-funded California Healthcare for Indigent Program (CHIP), county programs, or grant programs for some or all of their financial responsibility depending upon their specific circumstances.

B. Patients with demonstrated financial need may be eligible if they satisfy the definition of a Charity Care patient or High Medical Cost patient as defined in section IV, below.

C. This policy permits non-routine waivers of patients' out-of-pocket medical costs based on an individual determination of financial need in accordance with the criteria set forth below. This policy and the financial screening criteria must be consistently applied to all cases throughout the Medical Center.

D. This policy excludes services which are not medically necessary or separately-billed physician services. Emergency room physicians are included under a separate policy.

E. This policy will not apply if the patient/responsible party provides false information about financial eligibility or if the patient/responsible party fails to make every reasonable effort to apply for and receive government-sponsored insurance benefits for which they may be eligible.

F. This policy is intended to serve the residents of the local community of Orange County. It will apply to all those in need of emergent services including non local residents. However, non-emergent care for those that do not reside in Orange County and could be rendered elsewhere is specifically excluded from coverage under this policy.

IV. DEFINITIONS

A. "Charity Care Patient"- A Charity Care Patient is a financially eligible self-pay patient or a high medical cost patient.

B. "Federal Poverty Level" or "FPL" – The poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services. California Health & Safety Code §127400(b).

C. "Bad Debt" – A bad debt results from services rendered to a patient who is determined by the Medical Center, following a reasonable collection effort, to be able but unwilling to pay all or part of the bill.

D. "Financially Qualified Patient" – A patient who is: (1) a "*Self-Pay Patient*" or a "*High Medical Cost Patient*" and (2) a patient who has a family income that does not exceed 350% FPL. California Health & Safety Code §127400(c).

E. "Self-Pay Patient" – A financially eligible Self-Pay patient is defined as follows:

1. A patient who has no third party coverage; and
2. Has no Medi-Cal/Medicaid coverage, or patients who qualify but who do not receive coverage for all services or for the entire stay; and
3. Has no compensable injury for purposes of government programs, workers' compensation, automobile insurance, other insurance, or third party liability as determined and documented by the hospital; and
4. Whose family income is at or below 350% of the Federal Poverty Level (FPL).

F. "High Medical Cost patient" – A High Medical Cost patient is defined as:

1. A patient whose family income is at or below 350% of the Federal Poverty Level; and

2. Who does not receive a discounted rate from the hospital as a result of his or her third-party coverage; and

2. Whose out-of-pocket medical expenses in the prior twelve (12) months (whether incurred in or out of any hospital) exceeds 10% of family income.

G. "Patient's Family" – For patients 18 years of age and older, patient's family is defined as their spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not. For persons under 18 years of age, patient's family includes a parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

H. "Medically Necessary Service" – A medically necessary service or treatment is one that is absolutely necessary to treat or diagnose a patient and could adversely affect the patient's condition, illness or injury if it were omitted, and is not considered an elective or cosmetic surgery or treatment.

V. COMMUNICATION OF CHARITY CARE AND DISCOUNT POLICIES

Responsibility: Admitting, Emergency Room, Outpatient Settings, Patient Financial Services, Billing Office

A. Patients will be provided a written notice with their bill that contains information regarding the hospital's charity care policy, including information about eligibility, as well as contact information for a hospital employee or office from which the patient may obtain further information about these policies. At the time of service, notices are to be given to patients that do not appear to have third party coverage, in the Admitting Department, Emergency Room and other outpatient hospital settings. Notices should be provided in English and in languages as determined by the Medical Center's geographical area. (See Attachment A).

B. The Medical Center's Patient Financial Services shall publish policies and train staff regarding the availability of procedures related to patient financial assistance.

C. Notice of our Charity Care Policy will be posted in conspicuous places throughout the hospital, including the Emergency Department, Admissions Offices, Outpatient settings and the Patient Financial Services Department, in languages as determined by the Medical Center's geographical area.

D. For notices to include in a bill or statement for a patient who has not provided proof of coverage, see Section XI. Patient Billing and Collection Practices, Part A.

VI. ELIGIBILITY PROCEDURES

Responsibility: Admitting/Registration, Emergency Department, Outpatient Settings, Ancillary Registration Areas, Clinics, Patient Financial Services

A. Every effort will be made to screen all patients identified as uninsured or in need of financial assistance for admissions, emergency and outpatient visits for the ability to pay and/or determine eligibility for payment programs, including those offered through the Medical Center. Screened patients' financial information will be monitored as appropriate. Screened patients will be provided assistance in assessing patient eligibility for Medi-Cal or any other third party coverage.

B. Patients without third party coverage will be financially screened for eligibility for state and federal governmental programs as well as charity care funding at the time of service

or as near to the time of service as possible. If the patient does not indicate coverage by a third-party payer, or requests a discounted price or charity care, the patient should be provided with an application for the Medi-Cal program, the Healthy Families program, California Children's Services (CCS) or state-funded governmental program before the patient leaves the hospital, emergency room or other outpatient setting.

C. Patients with third party coverage with high medical costs (a patient that does not otherwise receive a discount for the services to be billed as a result of a third party coverage) will be screened by a Financial Counselor in the Admitting Department or Patient Financial Services to determine whether they qualify as a High Medical Cost patient. Upon patient request for a charity care discount, the patient will be informed of the criteria to qualify as a High Medical Cost patient and the need to provide receipts if claiming services rendered at other providers in the past twelve months. It is the patient's decision as to whether they believe that they may be eligible for CHIP/charity and wish to apply. However, the hospital must insure that all information pertaining to the Charity Care Discount Policy was provided to the patient.

D. All potentially eligible patients must apply for assistance through State, County and other programs before CHIP/charity care funds are considered. If denied, the Medical Center must receive a copy of denial. Failure to comply with the application process or provide required documents can be considered in the determination of eligibility. Willful failure by the patient to cooperate may result in the Medical Center's inability to provide financial assistance.

E. The Chip Patient Screening Form and/or Medi-Cal/MSI Screening Form (see Attachments B and C) are used to determine a patient's ability to pay for services at the Medical Center and/or to determine a patient's possible eligibility for public assistance.

F. All uninsured patients will be offered an opportunity to complete a Chip Patient Screening Form and/or Medi-Cal/MSI Screening Form. The forms are available in English and in languages as determined by the Medical Center's geographical area.

G. The Charity Care Discount financial screening and means testing will be performed by Financial Counselors in the Admitting Department and Patient Financial Services. It is the patient's responsibility to cooperate with the information gathering process.

H. Patient-specific information will be provided to the County and State in accordance with County and State guidelines for eligibility determinations.

VII. ELIGIBILITY FOR 100% CHARITY CARE

A. Patients without third party coverage and with family income at or below 200% of the FPL will be extended a 100% charity care discount on services rendered.

B. Means testing consists of a review of the patient's income and assets.

C. The Chip Patient Screening Form and/or Medi-Cal/MSI Screening Form should be completed for all patients requesting a charity care discount.

D. Criteria and process to determine a patient's eligibility for a 100% charity care discount are as follows:

1. Patient's family income will be verified not to exceed 200% of FPL with the most recent filed Federal tax return or recent paycheck stubs.
2. In determining eligibility for Charity Care, the Medical Center may consider income and monetary assets of the patient and/or family. Monetary assets include bank accounts and assets readily convertible to cash including stocks. Monetary assets shall not include retirement or deferred compensation plans (both qualified and non-qualified).
3. The first $10,000 of a patient's monetary assets shall not be counted in determining eligibility.
4. Only 50% of the patient's monetary assets exceeding the first $10,000 shall be counted in determining eligibility.
5. High Medical Cost patients with third party coverage whose family incomes are below 200 % of the FPL with medical costs in excess of 10 % of the patient's family annual income for the past 12 months, and who have not received a discount as a result of third party coverage for the services to be billed, will be extended a 100 % charity care discount on services rendered. The Medical Center may require the patient to provide documentation of patient's medical expenses.
6. Patients who qualify for 100% charity care on the basis of high medical costs shall receive such charity care discount only if they do not otherwise receive a discount as a result of third party coverage for the services to be billed.
7. High Medical Cost patients will be evaluated monthly for eligibility determination, and their status will be valid for the current month or most current service month retroactive to twelve months of service.

VIII. ELIGIBILITY FOR PARTIAL CHARITY CARE DISCOUNT FOR PATIENTS WITH NO THIRD PARTY COVERAGE

A. Patients with no third party coverage and with family income between 201% and 350% of FPL are eligible for a partial charity care discount.

B. The Chip Patient Screening Form and/or Medi-Cal/MSI Screening Form should be completed for all patients requesting a charity care discount.

C. Criteria and process to determine a patient's eligibility for a partial charity care discount are as follows:

G.

1. Patient's family income will be verified with either the most recent filed Federal tax return or recent paycheck stubs.
2. Once it is determined that a patient's family income is between 201% and 350% of the poverty level, monetary assets will be considered in the eligibility determination for a charity care discount. Monetary assets include bank accounts and assets readily convertible to cash including stocks. Monetary assets shall <u>not</u> include retirement or deferred compensation plans (both qualified and non-qualified).
3. The first $10,000 of a patient's monetary assets shall not be counted in determining eligibility.
4. Only 50% of the patient's monetary assets exceeding the first $10,000 shall be counted in determining eligibility.

D. Discounted payments will be limited to the highest of Medicare, Medi-Cal, Healthy Families, or any other government-sponsored health program in which the hospital participates. If the Medical Center provides a service for which there is no established payment by Medicare or any other government-sponsored program of health benefits in which the hospital participates, the hospital shall establish an appropriate discounted payment.

IX. ELIGIBILITY FOR PARTIAL CHARITY CARE DISCOUNT FOR HIGH MEDICAL COST PATIENTS WITH THIRD PARTY COVERAGE

A. High Medical Cost patients (as defined above) with third party coverage whose family incomes are between 201% and 350% of FPL with high medical costs are eligible for a partial charity care discount.

B. Patient is required to provide proof of payment of medical costs. Proof of payment may be verified.

C. The Chip Patient Screening Form and/or Medi-Cal/MSI Screening Form should be completed for all patients requesting a charity care discount. High Medical Cost patients need to be evaluated monthly to accurately account for medical cost for the last twelve (12) months.

D. Criteria and process to determine a patient's eligibility for a partial charity care discount are as follows:

H.

1. Patient's family income will be verified with either the most recent filed Federal tax return or recent paycheck stubs to confirm that the patient's family income is between 201 % and 350 % of the FPL.
2. Once it is determined that income is between 201% and 350% of the poverty level, no assets will be considered in the determination for a charity care discount. Eligibility will be based on the patient's family income qualification only.

E. Discounted payments will be limited to the highest of Medicare, Medi-Cal, Healthy Families, or any other government-sponsored health program in which the hospital participates. If the Medical Center provides a service for which there is no established payment by Medicare or any other government-sponsored program of health benefits in which the hospital participates, the hospital shall establish an appropriate discounted payment.

F. If a non-contracted third-party payer (who has not otherwise negotiated a discount off of the Medical Center's standard rates) has paid an amount equal to or more than the maximum governmental program payment, the Medical Center would consider the difference as a partial charity care discount, and write off the difference. If payment received is less than the maximum governmental program payment, the Medical Center can collect from the patient the difference between the third-party payment and the acceptable governmental program payment. However, <u>this policy does not waive or alter any contractual provisions or rates negotiated by and between a Medical Center and a third party payer, and will not provide discounts to a non-contracted third party payer or other entities that are legally responsible to make payment on behalf of a beneficiary, covered person or insured.</u>

G. Patients are not eligible for a partial charity care discount if they have otherwise received a discount as a result of third party coverage, as in the case of a payer contracted with the hospital.

H. For patients with no third party coverage whose incomes are above 350% of the Federal Poverty Level, please refer to the Uninsured Discount Policy.

X. REVIEW PROCESS

Responsibility: Admitting/Registration and Patient Financial Services

A. Requirements above will be reviewed and consistently applied throughout the Medical Center in making a determination on each patient case.

B. Information collected in the Chip Patient Screening Form and/or Medi-Cal/MSI Screening Form may be verified by the Medical Center. A waiver or release may be required authorizing the hospital to obtain account information from a financial or commercial institution or other entity that holds or maintains the monetary assets to verify their value. The patient's signature on the Patient Financial Assistance form will certify that the information contained in the form is accurate and complete.

C. Any patient, or patient's legal representative, who requests a charity care discount under this policy shall make every reasonable effort to provide the hospital with documentation of income and all health benefits coverage. Failure to provide information would result in denial of charity care discount.

D. Eligibility will be determined based on patient's family income including monetary assets as outlined in Assembly Bill 774, as revised by SB 350 (Chapter 347, Statutes of 2007), Health & Safety Code Section 127400 et al, Hospital Fair Pricing Policy.

E. The Chip Patient Screening Form and/or Medi-Cal/MSI Screening Form will be required each time the patient is admitted and is valid for the current admission plus any other outstanding patient liability at the Medical Center at the time of determination. The inpatient application can be used in the determination of charity care discount for outpatient services. The financial screening application for outpatient services is valid for three calendar months starting with the month of eligibility determination and any other patient financial liability at the Medical Center at the time of determination.

F. Patients who are homeless or expire while admitted to the Medical Center and have no source of funding or responsible party or estate may be eligible for charity care even if a financial assistance application has not been completed. All such cases must be approved by the Admitting Director, Patient Financial Services Director or their designees.

G. Patient will be notified in writing of approval or reason for denial of charity care eligibility in languages as determined by the Medical Center's geographical area pursuant to federal and state laws and regulations.

H. Specific payment liability for partial charity care discounts will require the episode of care or treatment plan to be determined and priced to enable accuracy of federal healthcare program reimbursement reporting. For patients with third party coverage with high medical costs, it may be necessary to wait until a payer has adjudicated the claim to determine patient financial liability.

I. For appeals and reporting, see Section XII Appeals/Reporting Procedures.

XI. PATIENT BILLING AND COLLECTION PRACTICES

Responsibility: Patient Financial Services

A. Patients who have not provided proof of coverage by a third party at the time or before care is provided will receive a statement of charges for services rendered at the hospital. Included in that statement will be a request to provide the hospital with health insurance or third party coverage information. An additional statement will be provided on the bill that informs the patient that if they do not have health insurance coverage, the patient may be eligible for Medi-Cal, Healthy Families, California Children's' Services or charity care. Patients will also be provided with information regarding the hospital's charity care policy, including information about eligibility, as well as Medical Center contact information to obtain further information about these policies.

B. Patient's request for charity care or discount information can be communicated verbally or in writing and a Patient Financial Information form will be given/mailed to patient/guarantor address. Written correspondence to the patient shall also be in the languages as determined by the Medical Center's geographical area pursuant to federal and state laws and regulations.

C. If a patient is attempting to qualify for eligibility under the hospital's charity care policy, and is attempting in good faith to settle the outstanding bill, the hospital shall not send the unpaid bill to any collection agency or other assignee unless that entity has agreed to comply with this policy.

D. Patients are required to report to the Medical Center any change in their financial information promptly.

E. Patients can be offered an extended payment plan. The terms of the payment plan can be negotiated by the hospital and the patient. Extended payment plans will be interest-free. Standard payment plan length will be twelve (12) months. Longer payment plans can be provided on an exception basis.

F. The Medical Center's 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 Medical Center's extended payment plan no longer operative, the Medical Center shall:

1. make a reasonable attempt to contact the patient by phone and, to give notice in writing, to the last known phone number and address of the patient to inform the patient that the extended payment plan may become inoperative, and of the opportunity to renegotiate the extended payment plan;
2. attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient;
3. not report adverse information to a consumer credit reporting agency or commence a civil action against the patient or responsible party for nonpayment prior to the time the extended payment plan is declared to be no longer operative and no less than 150 days after the initial patient billing.

G. If the patient fails to make all consecutive payments for 90 days and fails to renegotiate a payment, the patient is still obligated to pay the Medical Center the balance due. The period shall be extended if the patient has a pending appeal for coverage of the services, until a final determination of that appeal is made, if the patient makes a reasonable effort to communicate with the Medical Center about the progress of any pending appeals.

H. Prior to commencing collection activities against a patient, the Medical Center and its assignees of any patient debt, including collection agencies, shall provide the patient with a clear and conspicuous notice containing both of the following:
   1. A plain language summary of the patient's rights pursuant to AB 774 and SB 350, the Rosenthal Fair Debt Collection Practices Act, and the federal Fair Debt Collection Practices Act of Chapter 41 of Title 15 of the United States Code.
   2. A statement that nonprofit credit counseling may be available.

I. The Medical Center or its contracted collection agencies will undertake reasonable collection efforts to collect amounts due from patients. These efforts will include assistance with application for possible government program coverage, evaluation for charity care, offers of no-interest payment plans, and offers of discounts for prompt payment. Neither the Medical Center nor its contracted collection agencies will impose wage garnishments or liens on primary residences except as provided below. This requirement does not preclude the Medical Center from pursuing reimbursement from third party liability settlements or other legally responsible parties.

J. Agencies that assist the hospital and may send a statement to the patient must sign a written agreement that it will adhere to the hospital's standards and scope of practices. The agency must also agree to:
   1. Not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after initial billing.
   2. Not report adverse information to a consumer credit reporting agency or commence a civil action against the patient or responsible party for nonpayment prior to the time the extended payment plan is declared to be no longer operative.
   3. Not use wage garnishments, except by order of the court upon noticed motion, supported by a declaration file by the movant identifying the basis for which it believes that the patient has the ability to make payments on the judgment under the wage garnishment, which the court shall consider in light of the size of the judgment and additional information provided by the patient prior to, or at, the hearing concerning the patient's ability to pay, including information about

probable future medical expenses based on the current condition of the patient and other obligations of the patient.

4. Not place liens on primary residences.
5. Adhere to all requirements as identified in AB774 as revised by SB 350 (Health & Safety Code Section 127400 et seq).

K. In the event that a patient is overcharged by an amount of five dollars ($5.00) or more, the Medical Center shall reimburse the patient the overcharged amount with interest. Interest owed by the Medical Center to the patient shall accrue at the rate set forth in Section 685.010 of the Code of Civil Procedure, beginning on the date when the payment by the patient is received by the Medical Center. If a patient is overcharged by an amount that is less than five dollars ($5.00), the Medical Center: (i) is not required to reimburse the patient or pay interest, (ii) shall register the overpaid amount as a credit balance for the patient, and (iii) shall make the credit balance available for a period of at least 60 days to offset any amounts due to the Medical Center from the patient for subsequent services.

XII. APPEALS/REPORTING PROCEDURES

Responsibility: Patient Financial Services

A. In the event of a dispute or denial, a patient may seek review from the Customer Service Manager. The senior leadership of the Patient Financial Services Department will review a second level appeal.

B. The Charity Care policy, Discount Payment policy, and Patient Financial Information form shall be provided to the Office of Statewide Health Planning and Development (OSHPD) at least biennially on January 1, or with significant revision. If no significant revision has been made by the Medical Center since the policies and financial information form was previously provided, OSPHD will be notified that there has been no significant revision.

XIII. RESPONSIBILITY

Questions about the implementation of this policy should be directed to the Director of Patient Financial Services at (714) 456-6279. Questions about Financial Assistance eligibility should be directed to the Director of Admitting at (714) 456-6623 and/or the Assistant Director, PFS at (714) 456-7288.

XIV. ATTACHMENTS

A. Charity Care Notice
B. Chip Patient Screening Form
C. Medi-Cal/MSI Screening Form

APPROVED:

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Stan Greengard, Director PFS	Morris Frieling, CFO