



I. PURPOSE

UC Irvine Medical Center strives to provide quality patient care and high standards for the communities we serve. This policy demonstrates **UC Irvine 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 **UC Irvine Medical Center** and a third party payer, nor is the policy intended to provide discounts to a non-contracted third party payer or any 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 Section 501 (r) of the Internal Revenue Code (IRC) as well as California Health & Safety Code § 127400 *et seq.* (AB 774), Hospital Fair Pricing Policies, effective January 1, 2007, updated January 1, 2011, and January 1, 2015 (SB 1276), and United States Department of Health and Human Services ("HHS") Office of Inspector General ("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 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.

Signs are posted throughout the facility to provide education about charity/FAP policies.

The hospital's website includes a copy of the policy and applications in English and Spanish.

Eligibility for financial assistance is determined by the inability of a patient to pay, versus bad debt as the unwillingness of the patient to pay. Charity Care does not include bad debt, contractual adjustments or unreimbursed costs. The financial status of each patient should be determined so that an appropriate classification and distinction can be made between charity care and bad debt.

The hospital or its collection agency(s) will not exercise any Extraordinary Collection Activities (ECAs) against an individual whose eligibility has not been determined before 120 days after the first post discharge billing statement.

II. SETTING

This policy covers hospital inpatient and outpatient departments. An emergency physician, as defined in 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 percent of the FPL. **"Emergency Room physician fees are not covered under this policy"**. All other physician fees are excluded.



III. POLICY

- A. This policy is designed to provide assistance to Financially Qualified Patients¹ 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 a Medical Center. If application of this policy conflicts with payer contracting or coverage requirements consult with Medical Center legal counsel.
- D. This policy excludes services that are not medically necessary or separately-billed physician services. **"Emergency Room physician services are not covered under this 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, comply with requests, and receive government-sponsored insurance benefits for which they may be eligible.

IV. DEFINITIONS

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

¹ California Health & Safety Code § 127400(c) defines Financially Qualified Patients as "a patient who is both of the following: (1) A patient who is a self-pay patient, as defined in subdivision (f), or a patient with high medical costs, as defined in subdivision (g). (2) A patient who has a family income that does not exceed 350 percent of the federal poverty level."



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- C. “Emergent medical condition” – is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
 - 1. Placing the patient’s health in serious jeopardy;
 - 2. Serious impairment to bodily functions;
 - 3. Serious dysfunctions of any bodily organ or part.
 - D. “High Medical Cost patient” – A financially eligible High Medical Cost patient is defined as follows:
 - 1. Not Self-Pay (has third party coverage)
 - 2. Family income at or below 400% of the Federal Poverty Level (FPL)
 - 3. Out-of-pocket medical expenses in prior twelve (12) months (whether incurred in or out of any hospital) exceeds 10% of family income
 - E. “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.
 - F. “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 means a parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.
 - G. “Reasonable payment plan” – Monthly payments that are not more than 10 percent of a patient’s family income for a month, excluding deductions for essential living expenses. “Essential living expenses” means, for purposes of this subdivision, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, 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.
 - H. “Self-Pay Patient” – A financially eligible Self-Pay patient is defined as follows:
 - 1. No third party coverage;
 - 2. No Medi-Cal/Medicaid coverage or patients who qualify but who do not receive coverage for all services or for the entire stay²;

² This includes charges for non-covered services, denied days or denied stays. Treatment Authorization Requests (TAR) denials and any lack of payment for non-covered services provided to Medi-Cal patients are also included. In addition, Medicare patients who



3. 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;
4. Family income is at or below 400% of the Federal Poverty Level (FPL)

V. COMMUNICATION OF CHARITY CARE AND DISCOUNT POLICIES

Responsibility: Admitting, Emergency Department, Outpatient Settings, and Patient Financial Services.

- A. Patients will be provided a written notice with their bill that contains information regarding UC Irvine Medical Center'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 Department, Patient Financial Services Department and other outpatient hospital settings. Notices should be provided in English and in languages as determined by **UC Irvine Medical Center** geographical area. See [Appendix A].
- B. **UC Irvine Medical Center's** Patient Financial Services **department** shall publish policies and train staff regarding the availability of procedures related to patient financial assistance.
- C. Notice of this Charity Care Policy will be posted in conspicuous places throughout the hospital including the Emergency Department, Admissions Offices, Outpatient settings, and **Patient Financial Services Department**, in languages as determined by **UC Irvine 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, etc.**

- 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 **UC Irvine Medical Center**. Screened patients' financial information will be documented and retained as appropriate.

have Medi-Cal coverage of their co-insurance and/or deductibles, for which Medi-Cal does not make payment and Medicare does not ultimately provide bad debt reimbursement are also included.



Screened patients will be provided assistance in assessing patient eligibility for Medi-Cal or any other third party coverage, including coverage offered through the California Health Benefit Exchange.

- 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 screened for the Medi-Cal program, the Healthy Families program, coverage offered through the California Health Benefits Exchange, California Children's Services (CCS), or other state- or county- funded health coverage program before the patient leaves the hospital. For emergency department or other outpatient settings, after the screening, the patient should be scheduled for an appointment with Central Registration in order to complete the application. The patient also shall be provided with a referral to a local consumer assistance center housed at legal services offices.
- C. Patients with third party coverage with high medical costs will be screened by a financial counselor in Patient Access, or a representative from the Patient Financial Services Department 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 care 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, **UC Irvine Medical Center** must receive a copy of denial. Failure to comply with the application process or provide required documents will be considered in the determination. Willful failure by the patient to cooperate will result in **UC Irvine Medical Center's** inability to provide financial assistance.
- E. The **Charity Screening Form** is used to determine a patient's ability to pay for services at **UC Irvine 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 **Charity Screening Form**. The form is available in English and for languages in **UC Irvine Medical Center's** geographical area.
- G. The Charity Care Discount financial screening and means testing will be performed by **the Customer Service Representatives** in the **Patient Financial Services Department**. It is the patient's responsibility to cooperate with the information gathering process.



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- H. Patient-specific information will be provided to the County and State in accordance with County and State guidelines for eligibility determinations.
 - I. If a patient applies, or has a pending application, for another health coverage program at the same time that he or she applies for a Charity Care Discount, neither application shall preclude eligibility for the other program.

VII. ELIGIBILITY FOR 100% CHARITY CARE

- A. Patients without third party coverage and with family income at or below 400% of the FPL will be extended a 100% charity care discount on services rendered, **if the patient:**
 - (i.) **requires emergent medical care**
 - (ii.) **resides in the Medical Center's primary service area as defined in [Appendix A] and**
 - (iii.) **is uninsured, is ineligible for third party assistance or has high medical cost".**
- B. Means testing consists of a review of the patient's income and assets.
- C. The Charity 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 is verified not to exceed 400% of FPL with the most recent filed Federal tax return or recent paycheck stubs.
 2. The first \$10,000 of monetary assets (liquid assets) is not counted in determining eligibility.
 3. Only 50% of a patient's monetary assets (liquid assets) above the first \$10,000 is counted in determining eligibility.
 4. Retirement accounts and IRS-defined deferred-compensation plans (both qualified and non-qualified) are not considered monetary assets and are excluded from consideration.
 5. Assets above the statutorily excluded amounts will be considered exceeding allowable assets and may result in denial of charity care discounts.
 6. High Medical Cost patients with third party coverage whose family incomes are at or below 200% of the FPL will be extended a 100 % charity care discount on services rendered.
 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



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8. **“The Director of Patient Financial Services or the Chief Financial Officer may—under unusual circumstances—extend charity care to individuals who would not otherwise qualify for charity care under this policy. When such an award is made, the unusual circumstances justifying the award of charity care will be documented in writing and maintained in a segregated file in the Patient Financial Services Department.**

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

- A. Patients who have family incomes at or below 200% of the FPL—but who do not qualify for 100% charity care under Part VII of this Policy—will nonetheless qualify for a partial charity care discount so long as they are uninsured, require emergent medical care, reside in **UC Irvine Medical Center’s** primary service area as defined in **[Appendix A]**, and are ineligible for third party assistance or have high medical cost.
- B. Patients with no third party coverage with family income between 201% and 400% of the FPL are eligible for a partial charity care discount.
- C. The **Charity Screening Form** should be completed for all patients requesting a charity care discount.
- D. Family income will be verified with either the most recent filed Federal tax return or recent paycheck stubs.
- E. Once it is determined that a patient’s family income is between 201% and 400% of the FPL, monetary assets (assets that are readily convertible to cash, such as bank accounts and publicly traded stock) will be considered in the eligibility determination for a charity care discount.
- F. 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.

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

- A. High Medical Cost patients with third party coverage whose family incomes are between 201% and 400% of the 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 **Charity 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. 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 400 % of FPL.
- E. Once it is determined that income is between 201% and 400% of FPL, 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.
- F. 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.
- G. If a non-contracted third-party payer (who has not otherwise negotiated a discount off of **UC Irvine Medical Center's** standard rates) has paid an amount equal to or more than the maximum governmental program payment, **UC Irvine Medical Center** would consider the difference as a partial charity care discount, and write off the difference, excluding deductibles. If payment received is less than the maximum governmental program payment, **UC Irvine Medical Center** can collect from the patient the difference between the third-party payment and the acceptable governmental program payment. However, this policy does not waive or alter any contractual provisions or rates negotiated by and between **UC Irvine 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.
- H. Patients can be offered an extended payment plan. The terms of the payment plan shall be negotiated by the **UC Irvine Medical Center** and the patient, and take into consideration the patient's family income and essential living expenses. If the **UC Irvine Medical Center** and the patient cannot agree on the payment plan, the **UC Irvine Medical Center** shall use the formula described in the definition of "Reasonable Payment Plan," in section IV.G., above. 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.
- I. For patients with no third party coverage whose incomes are above 400% of the Federal Poverty Level, please refer to **Uninsured Discount Policy**.

X. REVIEW PROCESS

Responsibility: **Patient Financial Services Department**

- A. Requirements above will be reviewed and consistently applied throughout **UC Irvine Medical Center** in making a determination on each patient case.
- B. Information collected in the Charity Screening Form may be verified by UC Irvine 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 **Charity Screening 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 **UC Irvine Medical Center** 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 AB 774 (Health & Safety Code Section 127400 et seq.).
- E. The **Charity 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 **UC Irvine 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 six calendar months starting with the month of eligibility determination and any other patient financial liability at UC Irvine Medical Center at the time of determination.
- F. Patients who are homeless or expire while admitted to **UC Irvine 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 **Patient Financial Services Assistant Directors if under \$25,000 or the Patient Financial Services Director if over \$25,000** or their designees.
- G. Patients will be notified in writing of approval or reason for denial of charity care eligibility in languages as determined by **UC Irvine 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 will be necessary to wait until a payer has adjudicated the claim to determine patient financial liability. Patients are responsible for payment of all deductibles.
- I. See Section XII for 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 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 Program, coverage offered through the California Health Benefit Exchange, California Children's Services, other state- or county-funded health coverage, or charity care.

- B. Patient's request can be communicated verbally or in writing and a **Charity Screening Form** will be provided/mailed to patient/guarantor address. Written correspondence to the patient shall also be in the languages as determined by **UC Irvine 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 **UC Irvine Medical Center** any change in their financial information promptly.
- E. For financially eligible Charity Care patients, prior to commencing collection activities against a patient, the hospital and our agents will provide a notice containing a statement that nonprofit credit counseling may be available, and containing a summary of the patient's rights.
- F. **UC Irvine 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 uninsured discounts. Neither **UC Irvine 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 **UC Irvine Medical Center** from pursuing reimbursement from third party liability settlements or other legally responsible parties.
- G. 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.
 - a. 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 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.
 - 3. Not place liens on primary residences.



4. Adhere to all requirements as identified in AB 774 (Health & Safety Code Section 127400 et seq.).

5. Comply with the definition and application of a Reasonable Payment Plan, as defined in section IV.G., above.

H. In the event that a patient is overcharged, the hospital shall reimburse the patient the overcharged amount with 7 % interest (Article XV, Section 1 of the California Constitution) calculated from the date the patient made the overpayment.

XII. APPEALS/REPORTING PROCEDURES

Responsibility: **Patient Financial Services Department**

A. In the event of a dispute or denial, a patient may seek review from **Patient Financial Services Director or designee** who will review a second level appeal.

B. This Charity Care Policy, **Uninsured Discount Policy** and Charity Screening Form is to 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 **Patient Financial Services Director** since the policies and financial information form was previously provided, OSHPD will be notified that there has been no significant revision.

XIII. RESPONSIBILITY

Questions about the implementation of this policy should be directed to **the Patient Financial Services Department**.

Questions about Financial Assistance eligibility should be directed to **the Patient Financial Services Department**.

XIV. REFERENCES

Uninsured Discount Policy

University of California Accounting Manual (H-576-60)

Federal Regulations (42 C.F.R. Section 440.255)

XV. REVISION HISTORY

1/14/2015



APPENDIX A

PRIMARY SERVICE AREA

UC Irvine Medical Center defines its primary service area, as Orange County, South Orange County, San Bernardino and Riverside Counties.

Clinical Trial
Schedule & Unscheduled
At a Glance
Thresholds