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Policy Area: *Compliance Policy*

Charity Care Policy

I. PURPOSE

UCI Health strives to provide quality patient care and high standards for the communities we serve. This policy demonstrates UCI Health'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 UCI Health 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 enacted by the Affordable Care Act, and the implementing regulations, effective for tax years beginning after December 29, 2015 as well a 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. Uninsured patients who do not meet the criteria for Financial Assistance under this policy may be referred to the UCI Health Uninsured and Underinsured Discount Policy. Information regarding cash pricing can be found on the UCI Health website at <https://www.ucihealth.org/patients-visitors/financial-assistance>. The Financial Assistance Policy provides the procedures for identifying and handling patients who may qualify for Financial Assistance, the method by which patients may apply for Financial Assistance, the procedures by which the Hospitals' may use other information provided by a third party to presumptively determine eligibility for Financial Assistance, the basis for determining amounts to be charged to patients who are eligible for Financial Assistance under the policy, and the actions that may be taken by the Hospitals in the event of any non-payment.

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, Spanish and Vietnamese.

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 included, with a few exceptions.

III. POLICY

- A. This policy is designed to provide Financial assistance to Financially Qualified Patients^[1] who resides in UCI Health’s primary service area and/or meets other eligibility criteria outlined in this Financial Assistance Policy. UCI Health helps patients seeking assistance from all other available programs including the Federal and State-funded California Children’s Health Insurance Program (CHIP), Medi-Cal, Victim of Crime, county programs and any other sources of payment. Patients who are not eligible for assistance from another program may be eligible for Financial Assistance. UCI Health strives to make emergency and medically necessary care available to all patients regardless of their ability to pay.
1. 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.
 2. Patients or other individuals responsible for payment on patients’ behalf with demonstrated financial need may be eligible for Financial Assistance if they complete an application and meet the eligibility requirements for a full (100%) or partial Charity Care discount as defined in the Eligibility Procedures below. Patients who do not complete an application may be presumptively determined to be eligible for Financial Assistance using information provided by sources other than the patient or other individual seeking financial assistance in certain circumstances, as identified in the Presumptive Eligibility procedures below.
 3. Information about UCI Health’s Financial Assistance Policy shall be widely publicized, including on UCI Health’s website. Signs shall be conspicuously posted in the Emergency Department, registration areas, and outpatient departments and licensed clinics of the Hospitals notifying patients or other individuals responsible for payment for medical care of the Financial Assistance policy. A plain language summary of the Financial Assistance Policy shall be offered to potential eligible patients or other individuals responsible for payment during the check in or discharge process and during the billing and collections process. This information shall be provided in English, Spanish and any other language spoken by a significant Limited English Proficient (LEP) Population and shall be translated for patients or other individuals who speak other languages.

This policy permits non-routine waivers of patients’ out-of-pocket medical costs based on an individual determination of financial assistance need in accordance with the criteria set forth below. This policy and the financial screening criteria must be consistently applied to all cases throughout UCI Health. In exceptional circumstances, on a case-by-case basis after a good faith determination of financial need using the screening criteria and application identified in this Financial Assistance Policy, UCI Health may waive a patient’s coinsurance, co-payment, or deductible amounts.

4. This policy excludes services that are not medically necessary or separately billed physician services. **“Emergency Room physician services are not covered under this policy.”**
5. 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.

¹ California Health & Safety Code § 127400 et.al. 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 400 percent of the federal poverty level.”

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” means a full or partial waiver of a patient’s financial obligation for emergency and other medically necessary care furnished and billed by the Hospital, (including non-emergent physician services).
- C. “Charity Care Patient” – A Charity Care patient is a financially eligible self-pay patient or a high medical cost patient.
- D. “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.
With respect to a pregnant woman who is having contractions, emergency medication condition means that there is inadequate time to effect a safe transfer to another hospital for delivery or that transfer may pose a threat to the health or safety of the woman or unborn child.
- E. Extraordinary Collection Action (ECA) – “A list of collections activities as defined by the IRS and Treasury that Hospitals may take against an individual (or other person responsible for payment of the patient’s care) to obtain payment for care after reasonable efforts have been made to determine whether the individual is eligible for financial assistance. Per IRC 1.501(r)-6 and Treasury Regulation 1.501(r)-6(b)(1), certain sales of the patient’s debt to another party are considered an ECA. The following actions taken by a hospital are also considered ECAs:
 1. Placing a lien on an individual’s primary residence
 2. Foreclosing on real property
 3. Attaching or seizing an individual’s bank account or other personal property
 4. Commencing a civil action against an individual or writ of body attachment
 5. Causing an individual’s arrest

6. Garnishing wages
 7. Reporting adverse information to a credit agency
 8. Deferring or denying medically necessary care because of non-payment of a bill for previously provided care covered under UCI Health's Financial Assistance Policy
 9. Requiring a payment before providing medically necessary care because of outstanding bills for previously provided care.
- F. "Federal Poverty Level" (FPL) – Poverty guidelines, defined and published by the U.S. Department of Health and Human Services in the Federal Register, based upon income and family size.
<http://aspe.hhs.gov/poverty-guidelines>
- G. "Financial Assistance" – Both full Charity Care discounts and Partial Charity Care discount
- H. "Financially Qualified" – A Financially Qualified patient is defined as any patient where Patient's Family is at or below 400% of the FPL, including but not limited to:
1. Self-Pay Patient
 2. High Medical Costs Patient
 3. An insured patient with non-covered charges
- I. "High Medical Cost patient" – A financially eligible High Medical Cost patient is defined as follows:
1. Not Self-Pay (has third party coverage)
 2. Out-of-pocket medical expenses in prior twelve (12) months (whether incurred in or out of any hospital) exceeds 10% of family income
- J. "Medically Necessary Service" – A medically necessary service or treatment is one that is 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.
- K. "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.
- L. "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 childcare, child or spousal support, transportation, and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.
- M. "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
 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).

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 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.

V. COMMUNICATION OF CHARITY CARE AND DISCOUNT POLICIES

Responsibility: Admitting, Emergency Department, Outpatient Settings, and Patient Financial Services and the Single Billing Office.

- A. Patients will be provided a written notice with their bill that contains information regarding UCI Health'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 UCI Health geographical area. See [Appendix A].
- B. UCI Health'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 UCI Health's service area.
- D. For notices to include in a bill or statement for a patient who has not provided proof of coverage, see Section XII, "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 UCI Health. Screened patients' financial information will be documented and retained as appropriate.
- 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 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. The hospital must ensure 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, UCI Health 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 UCI Health's inability to provide financial assistance.
- E. The **Charity Screening Form** is used to determine a patient's ability to pay for services at UCI Health 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 UCI Health's service 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.
- 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 while 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. Self Pay 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, **if the patient:**
 - 1. **Requires emergent medical care**
 - 2. **Resides in the UCI Health's primary service area as defined in [Appendix A] and**
 - 3. **Is uninsured, is ineligible for third party assistance or has high medical cost"**.
- B. Self-Pay Patients with Patient's Family incomes between 201% and 400% of FPL may be eligible for a partial Charity Care discount on services rendered and billed by UCI Health for emergency and Medically Necessary Care. High Medical Cost Patients also may be eligible for a partial Charity Care Discount as set forth in the section below
- C. Means testing consists of a review of the patient's income and assets.
- D. The Charity Screening form should be completed for all patients requesting a charity care discount.
- E. 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 200% 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.
8. **"The Director of Patient Financial Services, the Executive Director of Revenue Cycle, 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 UCI Health'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. This policy does not waive or alter any contractual provisions or rates negotiated by and between a Hospital 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.
- G. Patients must be offered a Reasonable Payment Plan. The terms of the payment plan will be negotiated by the Single Billing Office (SBO). Reasonable Payment Plans will be interest-free, and the standard length of a payment plan is six (6) months. Longer payment plans can be provided on a case-by-case basis.

- H. If a non-contracted third-party payer (who has not otherwise negotiated a discount off of UCI Health's standard rates) has paid an amount equal to or more than the amount Medicare would allow for the service, as determined by the UCI Health and as described in the "Review Process" Section below, UCI Health would treat the difference between the amount paid by the third-party payer and UCI's standard charges for that service as a Charity Care discount, and write off that amount as Charity Care, if the patient is eligible for Charity Care under this Policy. If payment from the non-contracted third-party payer is less than the Medicare amount allowed for the service, UCI Health can collect from the patient the difference between the third-party payment and the Medicare allowed amount if the patient is not eligible for Charity Care under this Policy. If the patient is eligible for Charity Care under this Policy, UCI Health will treat the difference between the third-party payment and the Medicare allowed amount as a Charity Care discount and write off that amount as Charity Care.

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 UCI Health's standard rates) has paid an amount equal to or more than the maximum governmental program payment, UCI Health 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, UCI Health 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 UCI Health 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 UCI Health and the patient and take into consideration the patient's family income and essential living expenses. If the UCI Health and the patient cannot agree on the payment plan, the UCI Health 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. PRESUMPTIVE ELIGIBILITY

A. UCI Health understands that certain patients may be unable to complete a Financial Assistance application, comply with requests for documentation, or are otherwise non-responsive to the application process. As a result, there may be circumstances under which a patient's qualification for Financial Assistance may be established without completing the formal assistance application. Under these circumstances, UCI Health may utilize other sources of information to make an individual assessment of financial need to determine whether the individual is eligible for Financial Assistance. This information will enable UCI Health to make an informed decision on the financial need of non-responsive patients utilizing the best estimates available in the absence of information provided directly by the patient. In addition, presumptive eligibility for Financial Assistance may be determined based on individual life circumstances that may include:

- Homelessness or receipt of care from a homeless clinic
- Eligibility for food stamps
- Eligibility for school lunch programs
- Living in low-income or subsidized housing
- Patient is deceased with no estate

If a patient does not qualify for Financial Assistance under the presumptive eligibility procedures described above, the patient may still provide the required information and be considered under the Financial Assistance eligibility and application process set forth above.

XI. REVIEW PROCESS

Responsibility: **Patient Financial Services Department**

- A. Requirements above will be reviewed and consistently applied throughout UCI Health in deciding on each patient case.
- B. Information collected in the Charity Screening Form may be verified by UCI Health. 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 UCI Health 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.).
 1. Patient's Family income is verified with the most recent filed Federal tax return or a minimum of two recent paycheck stubs.

2. First \$10,000 of monetary assets (liquid assets) is excluded.
 3. 50% of all monetary assets (liquid assets) above \$10,000 are excluded.
- E. Assets above the statutorily excluded amounts will be considered exceeding allowable assets and may result in denial of Charity Care discount. 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 UCI Health 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 UCI Health at the time of determination.
- F. Patients who are homeless or expire while admitted to UCI Health 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, **SBO Assistant Director if under \$25,000 or the Patient Financial Services Director or Executive Director of Revenue Cycle if over \$25,000.**
- G. Patients will be notified in writing of approval or reason for denial of charity care eligibility in languages as determined by UCI Health's primary 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. In all cases, the amount charged to patients eligible for Financial Assistance shall be limited to the amounts generally billed to individuals who have insurance covering such care, as determined by UCI Health by using the billing and coding process UCI Health would use if the eligible patient were a Medicare fee-for-service beneficiary and setting the limit to the total amount Medicare would allow for the care (including both the amount that would be reimbursed by Medicare and the amount that the beneficiary would be personally responsible for paying in the form of co-payments, co-insurance or deductibles)
- J. See Section XII for Appeals/Reporting Procedures.

XII. 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 UCI Health's primary service 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 UCI Health 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. Patients are required to report to UCI Health any change in their financial information promptly.
- G. Bills that are not paid within 120 days after the first post-discharge billing statement may be placed with a collection agency, subject to limited exceptions. The patient or another individual responsible for payment may apply for assistance any time after the first post-discharge billing statement or any time during the collection process.
- H. UCI Health complies with the guidelines under Internal Revenue Code, Section 501(r) and UCI Health makes reasonable efforts to determine whether an individual is eligible for Financial Assistance under this Policy, as defined in Department of Treasury regulations Section 1.501(r)-6(c), as may be amended, prior to initiating an ECA.
- I. UCI Health 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. UCI Health nor its contracted collection agencies will impose wage garnishments or liens on primary residences. This requirement does not preclude UCI Health 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.
 - 1. The agency must also agree to:
 - a. 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.
 - b. Not use wage garnishments,
 - c. Not place liens on primary residences.
 - d. Adhere to all requirements as identified in AB 774 (Health & Safety Code Section 127400et seq.).
 - e. Comply with the definition and application of a Reasonable Payment Plan, as defined in section IV.G., above.
- K. If 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.

XIII. 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, OSPHD will be notified that there has been no significant revision.

XIV. 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.

XV. REFERENCES

- Uninsured Discount Policy
- University of California Accounting Manual (H-576-60)
- Federal Regulations (42 C.F.R. Section 440.255)

APPENDIX A: PRIMARY SERVICE AREA

PRIMARY SERVICE AREA

UCI Health defines its primary service area, as Orange County, South Orange County, San Bernardino, Riverside Counties and South Los Angeles.

Attachments

No Attachments

Approval Signatures

Approver	Date
Governing Body [FB]	05/2021
Medical Executive Committee [FB]	05/2021
Policy & Communications Cte [JL]	05/2021
Compliance & Privacy Office [TC]	04/2021