Manual	Business Office
Title	Financial Assistance, Charity Care & Billing Practices for Underinsured
Policy #	
Effective Date	01/2007
Revise Date	10/2022
Review Date	
Scope	California Hospitals
Reference	California Hospital Fair Pricing & Debt Collection

POLICY:

Vibra and its affiliated hospitals ("Vibra") are committed to providing financial assistance, charity care, and discounted payments for service provided. In addition, Vibra will provide written materials to patients and their representatives regarding its policies regarding discount payments and charity care for those individuals that meet the eligibility requirements outlined below. Finally, assistance in completing any applications for hospital discounted payments, charity care, or in the application for third party health insurance (i.e. Medicare, Medi-Cal, state or county-funded health insurance programs) will be offered to patients and their representatives.

Eligibility for charity care or discounted payments will be considered for those individuals that have met medical necessary criteria adopted by the hospital and as required by regulatory and accrediting agencies. In addition, the person receiving services must be accepted for admission by a physician or physicians that has/have been credentialed by the hospital Medical Staff and Governing Body.

Determination regarding charity care or discounted payment service will be in consideration of the information provided by the patient or their representative by the administrator or his/her designee.

I. Charity Care

a. Eligibility criteria may include, but is not limited to:
    i. Patients with income below 400% of the Federal Poverty Level (FPL)
    ii. No third-party payor
    iii. Limited assets not including those listed below
b. Both patient income and monetary assets of the patient will be considered but shall not include:
    i. Retirement or deferred compensation plans qualified under the Internal Revenue Code (i.e. 401K, IRA);
    ii. Nonqualified deferred compensation plans;
    iii. The patient's first $10,000 of assets; or
    iv. More than 50% of monetary assets over the first $10,000
c. Eligibility is at the discretion of the administrator

II. Discounted Payment
a. Eligibility Criteria
    i. Patients with high medical costs whose income is at or below 400% of the Federal Poverty Level (FPL)
b. Extended payment plan to allow payment of the discounted price over time
    i. The hospital and the patient will negotiate the terms of the payment plan and taking into consideration the patient's family income and essential living expenses.
    ii. If the two parties cannot agree on the plan, the hospital will use a formula described in Subdivision (i) of Section 1274000 to create a reasonable payment plan.

The granting of charity care or discounted payments shall not be based on an individualized determination of financial need and will NOT take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

Eligible persons may have payments adjusted on a sliding fee scale, in accordance with financial needs, as determined in reference to the FPL in effect at the time of the determination. The basis for the amounts charged for qualified persons is as follows:

- Patients whose family income is at or below 400% of the FPL may receive free care
- Patients whose family income is above 400% of the FPL but no more than 600% of the FPL are eligible to receive services at discounted rates

- Patients whose family income exceeds 600% of the FPL may be eligible to receive discounted rates on a case-by-case basis, based on their specific circumstances, such as catastrophic illness.
- Any expected payments from those patients eligible would not exceed the payments that would be expected from Medicare or Medi-Cal, whichever is greater. If there is no established payment for the service under Medicare or Medi-Cal, the hospital may establish an appropriate discount payment.

PROCEDURE:

I. Pre-Admission
    a. The hospital will make reasonable efforts to obtain from the patient or the patient's representative, information about whether private or public health insurance may fully or partially cover the charges for services provided by the hospital to the patient including, but not limited to:
        i. Private health insurance (including insurance offered through the state health benefit exchange)
        ii. Medicare
        iii. Medi-Cal or other state-funded health coverage programs
    b. The hospital will provide all persons without insurance a written estimate of the amount the hospital will require patients to pay for the health care services provided.

II. Patient Admission
    a. Upon admission (within 3 days of admission) the patient or their representative will be provided with written documents about the financial assistance policy (i.e. discounted payment and charity care) of the hospital which will include, but is not limited to:
        i. A statement indicating that if the patient lacks or has inadequate insurance and meets certain low- and moderate-income requirements that the patient may qualify for discounted payments or charity care.
        ii. The name and telephone number of the hospital administrator from which the patient may obtain information about discounted payments or charity care and how to apply for that assistance.

b. If the patient is not competent or able to receive the notice during the admission process, the notice will be provided at the latest during the discharge process or via United States Postal Mail within 72 hours of providing the service, and include:

    i. Eligibility criteria contact information for the hospital administrator where they may obtain additional information about the hospital policies.

    ii. The internet address for the Health Consumer Alliance (https://healthconsumer.org).

c. In addition, the hospital's policy regarding discounted payment and charity services will be posted in location(s) that are visible to the public, such as the admissions office and hospital lobby in addition to the hospital's internet website.

d. These notices will be made available in at least English and Spanish to meet the primary languages spoken in the community. For any patient who is unable to understand the information in the written formats available, the information will be provided by reading the information to the patient utilizing language or auditory interpreter services.

e. Patients admitted to the hospital that do not have coverage by a third-party payor or those that request a discounted price or charity care will receive an application and assistance in completing the application for the Medi-Cal program or other state- or county-funded health coverage program.

f. It is preferred, but not required, that a request for charity care or discounted payment and a determination of financial need occur prior to rendering medically necessary services. The determination may be done at any point and at any time additional information relevant to the eligibility of the patient becomes known.

III. Applications

a. Applications forms for charity care or discounted services will be provided to the patient or their representative from case management or hospital administration upon request.

b. The form provided is at the discretion of the hospital and may include, but is not limited to, personal, financial and other information as well as a release allowing information to be collected from banking institutions, employers, and other entities required to make a determination of financial need.

c. Patients that request a discounted payment, charity care or other assistance will be required to make every reasonable effort to

provide the hospital with documentation of income and health benefits coverage requested.

d. If the patient fails to provide information that is reasonable and necessary for the hospital to make a determination, the hospital will consider that failure in making a decision.

e. The following financial information will be requested at a minimum by the hospital based on the type of financial assistance:

    i. Discounted payment application – proof of income via either last three (3) months' pay stubs or income tax returns

    ii. Charity Care – all monetary assets except those of retirement or deferred compensation plans (i.e. 401k, IRA)

f. No information obtained through the financial discovery process will be used in the collection activities.

IV. Debt Collection

a. Any patient that is billed who has not provided proof of coverage by a third party during the patient admission will receive a clear and conspicuous notice that includes the following:

    i. A statement of charges for services provided

    ii. A request that the patient inform the hospital if the patient has any health insurance coverage as noted above

    iii. A statement that if the patient has no insurance/benefit coverage, the patient may be eligible for Medicare, Medi-Calm or coverage through other state- or county-health coverage, or charity care.

    iv. A statement indicating how patients may obtain applications for the Medi-Cal program, or state- or county-health coverage, and that the hospital will provide those applications upon request.

    v. Contact information for a local consumer assistance center at the legal services office.

b. Prior to initiating collection proceedings, the hospital will offer a reasonable payment plan to the qualified patient and allow for at least 180 days past the due date of any scheduled payment that is not paid in full. This only applies to the first late payment.

c. Patients with approved charity care will not be billed post discharge for services provided.

d. The hospital will make a good faith effort to establish a payment plan with the patient.

e. The hospital will have a written agreement with any entity that collects hospital receivables which indicates that the entity will adhere to the hospital's standards and scope of practices. The entity will comply with the hospital's definition and application of a reasonable payment plan, charity care policy and/or discount payment policy.

f. Before assigning a bill to collections, the hospital will send a patient a notice with the following information:

    i. The date or dates of service of the bill

    ii. The name of the entity that will collect the outstanding balance

    iii. A statement informing the patient how to obtain an itemized hospital bill.

    iv. The name and plan type of health coverage for the patient at the time

    v. An application for the hospital's charity care and financial assistance

    vi. The date(s) the patient was originally sent a notice about applying for financial assistance, the date(s) the patient was provided a financial assistance application, and, if applicable, the date a decision on the application was made.

g. No adverse information will be reported to a consumer reporting agency or commence civil actions against a patient for nonpayment before 180 days after initial billing.

h. If a patient is attempting to qualify for charity care or discount payments and is attempting, in good faith, to settle an outstanding bill either through negotiating a reasonable payment plan or making regular partial payments, the hospital will not send the unpaid bill to any collection entity.

i. Wage garnishments or liens on any primary residence will not be used as a means of collecting unpaid hospital bill.

DEFINITIONS:

Self-Pay Patients:

A patient who does not have third-party coverage from a health insurer, health care service plan, Medicare or Medicaid and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other

insurance as determined and documented by the hospital. Self-pay patients may include charity care patients.

Patient with High Medical Costs:

A person whose family income does not exceed 400% of the federal poverty level.

High Medical Costs:

High medical costs means any of the following:

1. Annual out-of-pocket costs incurred by the individual at the hospital that exceed the lesser of 10% of the patient's current family income or family income in the prior 12 months.
2. Annual out-of-pocket expenses that exceed 10% of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.
3. A lower level determined by the hospital in accordance with the hospital's charity care policy.