



## Hospital Charity and Discount Care Policy

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### **TITLE: Charity and Discount Policy**

**Purpose:** UHS River Vista Behavioral Health Hospital's mission is to provide the best care to every patient every day through integrated clinical practices, education and resources. River Vista Behavioral Health Hospital's commitment and belief is that the needs of the patients come first and appropriately to serve patients in difficult financial circumstances which include offers of financial assistance, and/or discounts to those who have established need to receive medically necessary services.

**Policy:** It is the policy of River Vista Behavioral Health Hospital, in compliance with California State Law AB774 (Hospital Fair Pricing Policies) to provide discounts from standard billed charges for all self-pay and high medical costs patients as defined below. Amount is established based on Federal Poverty Guidelines.

**Scope:** This document serves to establish, facilitate, plan, and engage in a fair and consistent method for review and completion of requests for Charitable medical care and or discounts as appropriate to the patients in need, provides guidance to facilitate, plan and engage with execution of self-pay collections and activities, and patients presenting for Charity Care.

This policy is to be used by River Vista Behavioral Health Hospital Admissions Coordinators/Financial Counselors to screen, educate and counsel patients presenting to the facility requesting/ requiring Charity assistance and or discounts as appropriate.

### **1.0 Roles and Responsibilities**

- **Admissions Coordinator/ Financial Assistance:** *responsible* for maintaining admissions, financial, charity discount policies and procedures.
- **Business Office Director:** Responsible for ensuring, and enforcing adherence to admissions, financial assistance, charity and discount policies and procedures.

## 2.0 Definitions:

**Self-pay patients:** Any patient who presents with the following attributes:

- No third-party insurance
- No Medi-Cal benefits
- No compensable injury for purposes of worker's compensation, automobile insurance, or other insurance as determined and documented by River Vista Behavioral Health Hospital admissions and insurance verification process
- Family income and the FPL at the time of service or first billing.

**High Medical Cost Patient:** A person (i) whose Family Incomes do not exceed four hundred percent (400%) of the Federal Poverty Level; and (ii) whose out-of-pocket costs exceed the following:

- Annual out-of-pocket costs incurred by the individual at the hospital that exceed the lesser of 10 percent (10%) of the patient's current family income or family income in the prior 12 months; or
- Annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

Out-of-pocket costs means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing

**Federal Poverty Level [FPL]:** A measure of income issued every year by the Department of Health and Human Services. Federal Poverty Levels are used to determine patient eligibility for certain programs and benefits including Charity and or Discounts. Federal Poverty Levels are defined by the United States Department of Health and Human Services.

**United States Department of Health and Human Services:** US Federal Government Department created to protect the health of all Americans and improving, monitoring and providing effective health, safety and well-being of human services; in the sciences underlying medicine public health and social services.

**Guarantor/Responsible Party:** responsible for repaying medical costs or care of patient receiving services at the hospital (including inpatient and outpatient services).

**I. Procedure:**

1. At the time of admission or as soon as practical after admission, all patients with no third-party coverage or with a potential deductible or co-pay responsibility will be provided by the Admissions/Financial Assistance Coordinator with notice of the availability of discounts or charity and the related application.
2. All individuals (patients, responsible party, guarantor) with no third-party coverage will also be notified that we have available applications for Medi-Cal and Healthy Families programs. Such applications will be provided to patients or responsible parties if requested.
3. All complete applications for discount will be evaluated for a discount or charity within 10 business days of receipt. Income levels are subject to verification by review of supporting documentation according to the following guidelines:
  - i. Reported income levels must be supported by either a check stub or income tax return.
  - ii. Failure to provide sufficient supporting documentation may exclude patients from qualifying for discount or charity.
4. After review of applications and supporting documentation, discounts or charity will be provided at the following levels:
  - I. Discounts and charity for those who qualify as Self Pay patients:
    1. All self-pay patients with income level between 251% and 400% of the FPL will have their stay discounted to the Medicare or Medi-Cal rate for the stay, whichever is greater. Additional discount is available at the discretion of the hospital.
    2. All self-pay patients with income levels between 101% and 250% of the FPL will have their stay discounted to no more than 50% of the Medicare or Medi-Cal rate for the stay, whichever is greater. Additional discount is available at the discretion of the

hospital.

3. Charity: All self-pay patients with income level at or below 100% of the FPL who meet the eligibility requirements of this policy shall qualify for a one hundred percent (100%) Charity care adjustment for eligible medical necessary services. Self-pay patients with income level at or below 100% of the FPL may qualify for charity care or discount at the discretion of the hospital.

II. Discounts for those who qualify as High Medical Cost patients:

1. All patients who qualify as High Medical Cost patients will be billed for deductibles and coinsurance only to the extent that third party payments received plus amounts billed to the patient do not exceed the higher of the payment that would be received from Medicare or Medi-Cal.
2. The hospital at its discretion may provide a greater discount to the patient than allowed under section 3.4.1.1 of this policy.
5. Any amounts due from the patient under this policy are eligible for extended, interest free payment plans. The payment plan will be established based on the negotiated agreement between RVBH and the patient, considering the patient's family income and necessary living expenses. If RVBH and the patient are unable to reach an agreement on a payment plan, RVBH will establish a reasonable plan in which the monthly payment does not exceed 10% of the patient's monthly family income, excluding living-expense deductions.
6. Patients may be referred to a collection agency after exhaustion of normal collection efforts. However, no patient will be referred to a consumer credit reporting agency by the hospital or its collection agency for non-payment.
7. The hospital or its agents **will not** use wage garnishments or liens on primary residences to collect debts from any patient.
8. **Eligibility disputes:** A patient, guarantor, or authorized representative who

disagrees with the determination regarding eligibility for charity care or discount payment may request review of the determination.

Requests for review shall be submitted to the Business Office Director, *Angelina Cruz*, within thirty (30) calendar days of the eligibility determination. The Business Office Director contact information can be found on our website <https://rivervistabh.com> in the admissions link under financial information.

The Business Office Director, or designated management representative who was not involved in the original eligibility determination, shall review the application, supporting documentation, and any additional information submitted by the patient.

The reviewer may request additional documentation necessary to complete the review.

A written determination will be provided to the patient within reasonable time frame following completion of the review period the determination made through the eligibility dispute review process shall be considered final.