Financial Assistance, Charity Care and Debt Collection Policy

Effective: 10/1/2025

SCOPE

This policy applies to the following hospitals:

- Central California Rehabilitation Hospital
- Rehabilitation Hospital of Southern California
- Sacramento Rehabilitation Hospital
- Stockton Regional Rehabilitation Hospital

PURPOSE

To provide a framework for the provision of financial aid, disclosure, and debt collection as set forth within California Hospital Fair Pricing Policies.

POLICY

The hospital is committed to providing financial assistance including charity care and discounted payments for services provided. In addition, the hospital will provide written materials to patients and their representatives describing its policies regarding discounted 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 medically 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 made, taking into consideration the information provided by the patient or their representative, by the hospital administrator or his/her designee.

Eligible persons may have payments adjusted on a sliding fee scale, based on financial needs, as determined by the Federal Poverty Levels (FPL) at the time the patient is first billed. The basis for the amounts charged for qualified persons is as follows:

- Patients whose family income is at or below 400% of FPL may receive free care.

- Patients whose family income is above 400% of the FPL but not 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 eligible patients 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 a discounted payment.

Communication about the hospital's charity program and discounted payments will be made publicly available and as conspicuously as possible. Methods of communication to the public include but are not limited to the provision of notices in patient bills, by posting notices in the hospital lobby, patient admission information, and on the hospital website.

The hospital may waive or reduce Medi-Cal and Medicare cost-sharing amounts as part of the hospital's charity care or discount payment program.

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

Charity Care:

- Eligibility criteria include:
    - Patients with income at or below 400% of the Federal Poverty Level
    - No third-party payor
- Patient income will be considered, but will not include, retirement, deferred compensation plans qualified under the Internal Revenue Code (i.e. 401K, IRA) or nonqualified deferred compensation plans.
- Monetary assets will not be considered when determining eligibility.
- Patients approved for charity care will not be billed post discharge for services provided.

Discounted Payment:

- Eligibility criteria include:
    - Patients with income at or below 400% of the Federal Poverty Level
- A health savings account held by the patient or patient's family may be considered when negotiating payment plans.

Extended Payment Plans:

- An extended payment plan will be offered to allow payment of the discounted price over time.
    - The hospital and patient will negotiate the terms of the payment plan taking into consideration the patient's family income and essential living expenses.
    - If the two parties cannot agree on the plan, the hospital will create a reasonable payment plan where monthly payments are not more than 10% of the patient's monthly family income, excluding deductions for essential living expenses.
    - Extended payment plans will be interest-free.
- The hospital may require a patient or guarantor to pay the hospital any amounts sent directly to the patient by third-party payers, including from legal settlements, judgments, or awards.

DEFINITIONS

Allowances for Financially Qualified Patient:

With respect to services rendered to a financially qualified patient, an allowance that is applied after the hospital's charges are imposed on the patient, due to the patient's determined financial inability to pay the charges.

Charity Care:

Free care.

Discounted Payment or Discount Payment:

Any charge for care that is reduced but not free.

Essential Living Expenses:

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 expense.

Federal Poverty Level:

The poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services.

Financially Qualified Patient:

A patient who is both:

1. A self-pay patient, or a patient with high medical costs
2. A patient who has a family income that does not exceed 400% of the federal poverty level.

Guarantor:

A person who has legal financial responsibility for the patient's health care services.

High Medical Costs:

Includes 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 patient's family in the prior 12 months.
3. A lower level as determined by the hospital in accordance with the charity care policy.

Out-of-Pocket Expenses:

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.

Patient's Family:

1. For persons 18 years of age and older, spouse, domestic partner, and dependent children under 21 years of age, or any age if disabled, whether living at home or not.

2. For persons under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker relatives, and parent's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled.

Patient with High Medical Costs:

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

Reasonable Payment Plan:

Monthly payments that are not more than 10% of a patient's family income for a month, excluding deductions for essential living expenses.

Self-Pay Patient:

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 the purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital. Self-pay patients may include charity care patients.

PROCEDURE

Prior to admission, the hospital will attempt to obtain information from the patient or the patient's representative about whether private or public health insurance may fully or partially cover the charges for services provided by the hospital to the patient.

Private and public health insurance includes, but is not limited to:

- Private health insurance (including insurance offered through the state health benefit exchange)
- Medicare
- Medi-Cal or other state-funded health coverage programs

The hospital will provide all persons without insurance with a written estimate of the amount the hospital will require patients to pay for the health care services provided.

Patient Notices:

Upon admission (within 3 days of admission), and at discharge, the patient or their authorized representative will be provided with written notices about the hospital's financial assistance policy (i.e. discounted payments and charity care), which will include, but is not limited to:

- A statement that if the patient lacks or has inadequate insurance and meets certain low- and moderate-income requirements, the patient may qualify for discounted payments or charity care.
- The name and telephone number of the hospital administrator from whom the patient may obtain information about discounted payments or charity care and how to apply for that assistance.
- Information on where the patient may access the hospital's discount payment and charity care policies.
- Eligibility information.
- The internet website for the hospital's list of shoppable services, if any.
- Statement regarding the Hospital Bill Complaint Program:
    - The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to: HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.
- Information on Health Consumer Alliance, including the following statement:
    - Help Paying Your Bill: There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information.
- Information about Covered California
- The URL for the hospital's price transparency files
- A tagline sheet with the following statement in the top 15 languages spoken by limited-English proficient ("LEP") individuals in California as determined by the State Department of Health Care Services:
    - ATTENTION: If you need help in your language, please call [hospital phone number] or visit the hospital Admissions Office. The office is open 8am to 5pm Monday through Friday and is located at [hospital address]. Aids and services for people with disabilities, like documents in braille, large print, audio, and other accessible electronic formats are also available. These services are free.
- If the patient is unconscious or is unable 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 and sent within 72 hours of providing the service.
- 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 interpreter services or having the notices translated as needed.

- Patients admitted to the hospital that do not have coverage by a third-party payer or those that request a discounted price or charity care will receive an application and assistance in completing an application for the Medi-Cal program or other state- or county-funded health coverage program.
- 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 made at any point and at any time additional information relevant to the eligibility of the patient becomes known.

Hospital and Website Notices:

The notices described above will be posted in locations that are visible to the public, such as the hospital lobby, and on the hospital's website.

Applications:

- Application forms for charity care or discounted services will be provided to the patient or their representative from case management or hospital administration upon request.
- Patients that request discounted payment, charity care or other assistance will be required to make reasonable efforts to provide the hospital with documentation of income and health benefits coverage requested.
- If the patient fails to provide information that is reasonable and necessary for the hospital to make a determination, the hospital may presumptively determine that the patient is eligible for charity care or discounted payment based on information other than that provided by the patient or based on prior eligibility determination.
- The hospital will request proof of income from the patient either through recent pay stubs or income tax returns.
    - Recent paystubs include those within a six (6) month period before or after the patient is first billed, or in the case of pre-service, when the application is submitted.
    - Recent tax returns include tax returns which document a patient's income for the prior 1-year in which the patient was first billed, or in the case of pre-service, when the application was submitted.
- The hospital will not consider the patient's monetary assets when determining eligibility for discount payment or charity care.

- The hospital may not require a patient to apply for Medicare, Medi-Cal, or other coverage before the patient is screened for, or provided, discounted payment.
    - The hospital may require patients to participate in screening for Medi-Cal eligibility.
- Eligibility for discounted payments or charity care may be determined at any time, and the hospital may not impose time limits on applying for charity care or discounted payments, nor deny eligibility based on the timing of the patient's application.
- Information obtained through the financial discovery process will not be used in any collection activities that may be taken.

Eligibility Determination:

- The hospital will issue a letter to the patient notifying them of the hospital's eligibility determination, which includes:
    - A clear statement of the hospital's determination of the patient's eligibility for the discount payment program and/or charity care program.
    - If the patient was denied eligibility for the discount payment and/or charity care program, a clear statement explaining why the patient was denied discount payment, charity care, or both.
        - If the denial was based on services not being medically necessary, the hospital must obtain an attestation, prior to denying eligibility for the discount payment and/or charity care program, stating that services aren't medically necessary. The attestation must be signed by the referring provider or supervising physician at the hospital.
    - If the patient was approved for discount payment or charity care, a clear explanation of the reduced bill and instructions on how the patient may obtain additional information regarding a reasonable payment plan, if applicable.
    - Information on the Hospital Bill Complaint Program, including the following:
        - The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program, go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.
    - Information on Health Consumer Alliance, including the following:
        - There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information.

- Information about Covered California
- The URL for the hospital's price transparency files
- The tagline sheet

Disputes:

- A patient may seek the review of any decision by the hospital to deny charity care or discounted payment by notifying the VP of Revenue Cycle Operations of the basis of the dispute and desired relief within thirty (30) days of the patient receiving the notice of the determination.
- Patients may submit the dispute orally by calling the VP of Revenue Cycle Operations at 972-216-2287 or by mailing the above information to 1024 N. Galloway Ave., Ste. 102 Mesquite, TX 75149.
- The VP of Revenue Cycle Operations will review the patient's dispute as soon as possible and inform the patient of any decision in writing.

Patient Complaint Process through HCAI:

- Upon notification from HCAI of a patient complaint regarding an eligibility determination for the hospital's discount payment and/or charity care program, the VP of Revenue Cycle Operations will provide a response within thirty (30) calendar days (unless and extension is granted) to HCAI that includes:
    - A detailed explanation of the hospital's current position on whether the patient qualified under the hospital's discount payment and/or charity care policies, including the terms of financial assistance offered, if any.
    - Copies of all documents and information relevant to the issues raised in the complaint, including, but not limited to, bills, written notices, and notes from communications between the hospital and the patient/patient's authorized representative.
- When notice of a patient complaint is received, any unpaid bills will not be sent to any collection agency, debt buyer, or other assignee unless the entity has agreed to comply with the requirements under the California Health and Safety Code sections 127400 through 127446.
- The VP of Revenue Cycle Operations will respond to any requests from HCAI for additional information within 30 calendar days, unless an extension is granted.
- If the VP of Revenue Cycle Operations is unable to provide the requested response(s) within 30 calendar days, the VP of Revenue Cycle Operations may request a reasonable extension of time through the online patient complaint portal.

- This request must be submitted prior to the due date and describe the actions being taken to obtain the information or records, and when receipt is expected.

Debt Collection:

- 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:
  - A statement of charges for services provided
  - A request that the patient inform the hospital if the patient has any health insurance coverage as noted above
  - A statement that if the patient has no insurance/benefit coverage, the patient may be eligible for Medicare, Medi-Cal, or coverage through state- or county-health coverage and that the hospital will provide those applications upon request.
- 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.
- The hospital will make a good faith effort to establish a payment plan with the patient.
- The hospital will have a written agreement with any entity that collects receivables that requires the entity to 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.
- Before assigning a bill to collections, the hospital will send a patient a notice with the following information:
  - The date or dates of service of the bill
  - The name of the entity that will collect on the bill
  - A statement informing the patient how to obtain an itemized hospital bill
  - The name and plan type of health coverage for the patient on record with the hospital at the time of services or a statement that the hospital does not have that information
  - An application for the hospital's charity care and financial assistance program
  - The date(s) the patient was originally sent a notice about applying for financial assistance, the date(s) the patient was provided with a financial assistance application, and, if applicable, the date a decision on the application was made

- The VP of Revenue Cycle Operations will determine whether a patient's debt will be advanced to collections under this policy.
- The hospital is prohibited from reporting adverse information about a patient's hospital debt to consumer credit reporting agencies.
- 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.
- The hospital or any contracted debt collection agency will not use any of the following as a means of collecting unpaid hospital bills:
    - Wage garnishments
    - Sale of any property owned, in part or completely, by the patient
    - Liens on any real property owned by the patient