LOMA LINDA UNIVERSITY
MEDICAL CENTER – MURRIETA

LOMA LINDA UNIVERSITY MEDICAL CENTER-MURRIETA

OPERATING POLICY

CATEGORY:	FINANCE	**CODE:**	M-C-22
		EFFECTIVE:	07/2025
SUBJECT:	FINANCIAL ASSISTANCE	**REPLACES:**	05/2025
		PAGE:	1 of 15

PURPOSE:

This policy describes the criteria and process used by Loma Linda University Medical Center-Murrieta (collectively referred to as LLUMC-M) to ensure compliance with state and federal laws, including section 501(r) of the Internal Revenue Code (IRC) of 1986, as amended, and the California Hospital Fair Billing Program (22 CCR §§ 96051 et seq). This policy describes LLUMC-M's Financial Assistance (Charity Care and Discounted Care) policy for its California hospitals. LLUMC-M provides Financial Assistance to patients and families when they are unable to pay all or part of their medical bill, based on the standards below.

SCOPE OF POLICY:

This policy covers financial assistance provided to patients by LLUMC-M for medically necessary services. All requests for financial assistance from patients, patient families, physicians or hospital staff will be handled according to this policy. This policy does not apply to physician services at LLUMC-M. Emergency physicians are not employed by LLUMC-M and have a separate policy that offers discounts to uninsured patients or patients with high medical costs. A list of providers that are NOT covered under the LLUMC-M FAP can be obtained at Financial Assistance Policy.

COMMITMENT TO PATIENT CARE:

LLUMC-M's mission is "To Continue the Teaching and Healing Ministry of Jesus Christ" with a commitment to "Make Man Whole." As a faith-based organization, LLUMC-M is dedicated to meeting the health care needs of patients in its service area. As a major teaching university and tertiary hospital, LLUMC-M serves as a regional resource, caring for complex patient needs. LLUMC-M offers many highly specialized treatment programs, some of which are unique. To help meet the needs of its patients, LLUMC-M is committed to providing access to financial assistance programs when patients are uninsured or underinsured and may need help in paying their hospital bill.

LLUMC-M provides, without discrimination, care for emergency medical conditions to individuals regardless of their ability to pay as required by the Federal Emergency Medical Treatment and Labor Act (EMTALA). LLUMC-M does not demand that emergency department patients pay before receiving treatment for emergency medical conditions. LLUMC-M does not permit debt collection activities that interfere with service or care.

DEFINITION OF TERMS:

Amount Generally Billed (AGB):

The amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. This is usually described as a percent of Gross Charges. Patients eligible for financial assistance will not be charged more than AGB for emergency and other medically necessary services. LLUMC-M uses a prospective method based on Medicare rates.

Charity Care:

Free care provided when a patient meets certain qualifications under this Financial Assistance policy.

Discounted Care:

A reduction in the amount a patient is expected to pay when the patient is uninsured or has insurance that does not cover the entire amount due, and the patient meets certain qualifications under this Financial Assistance policy.

Eligibility:

LLUMC-M uses only family size and family income in relation to Federal Poverty Level (FPL) Guidelines to determine individual patient eligibility for Financial Assistance. Family income is determined using only a copy of the patient's federal tax return or recent pay stubs. We will not use other "monetary assets" to determine patient financial assistance eligibility. Other monetary assets include retirement funds and deferred compensation plans. Patients whose income is 201%, but less than or equal to 400% of the FPL, including those patients who may have "High Medical Costs," are eligible for Discounted Care. Patients who meet other special circumstances may become eligible for Charity Care. Details for each specific patient situation are described more fully in the policy section F below.

Federal Poverty Level (FPL) Guideline:

The FPL guidelines establish the gross income and family size eligibility criteria for Charity Care and Discounted Care status as described in this policy. The FPL guidelines are updated periodically by the United States Department of Health and Human Services.

Guarantor:

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

Good Faith Estimate:

An amount that represents a reasonable approximation of the actual price for services received. Registration staff will make their best efforts to develop and quote a Good Faith Estimate; however, registration staff may not be able to fully predict the actual medical

services that will subsequently be ordered by the patient's attending, treating or consulting physician(s).

Gross Charges:

The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

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.

Medically Necessary Services:

Financial assistance under this policy applies to medically necessary services as defined by California Welfare & Institutions Code §14059.5. A service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. If the hospital determines that a particular service is not medically necessary, the referring physician and/or the supervising health care provider must sign an attestation and state the reason why the service is not medically necessary.

Patient's Family:

Patient's family means the following:

1. For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the California Family Code, and dependent children under 21 years of age, or any age if disabled, consistent with section 1614(a) of Part A of Title XVI of the Social Security Act, 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 consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.

Qualified Payment Plan:

Payment plans established through agreement between patients who have qualified for Discounted Care through the Financial Assistance Policy and LLUMC-M are classified as a Qualified Payment Plan. A Qualified Payment Plan will take into consideration the patient's family income and essential living expenses, as well as the availability of the patient's health savings account. It will not have interest charges applied to any or all balances due from the patient/guarantor. If LLUMC-M and the patient/guarantor cannot reach agreement on terms for a qualified payment plan, the hospital may establish a "reasonable payment plan.

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 mean expenses for rent or house payment, 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.

A. GENERAL PATIENT RESPONSIBILITIES

1 Under California Law, any patient or guarantor who requests financial assistance under this policy must make every reasonable effort to provide LLUMC-M with documentation of income and health care benefits. If the person requests financial assistance and fails to provide information that is reasonable and necessary for LLUMC-M to make a determination, LLUMC-M may consider that failure in making its determination.

2. Honesty: Patients must be honest and forthcoming when providing information requested by LLUMC-M as part of the financial assistance screening process. This includes accurate and truthful documentation necessary to determine eligibility for financial assistance coverage. Honesty means full and complete disclosure of required information and/or documentation.

3. Active Participation in Financial Screening: All those who request financial assistance must complete a Financial Assistance Application (FAA). Patients should verify any additional information or documentation needed. Patients are responsible for understanding and meeting document filing deadlines for LLUMC-M or other financial assistance programs. Hospital financial counselors are available to help.

4. Filing of Financial Assistance Application:

   Patients should complete the FAA as soon as they become aware they may be in need of financial assistance. The application form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged. Financial Assistance applications are accepted at any point where the patient makes a request, or when the hospital or its agents identify an individual patient's potential need.

5. Out-of-Pocket Amounts: Patients are expected to pay amounts due at the time of service. Out-of-pocket amounts may include, but are not limited to:

   5.1 Co-Payments

   5.2 Deductibles

   5.3 Deposits

5.4 Medi-Cal/Medicaid Share of Cost Amounts

5.5 Good Faith Estimates

6. Shared Responsibility for Hospital Care: Patients share responsibility for their hospital care. This includes ensuring that arrangements for settling the patient account have been completed. Cooperation and communication with LLUMC-M personnel before, during and after services is essential.

B. HOSPITAL PROCESS AND RESPONSIBILITIES

1. Eligibility. Patients with family income less than 400% of the federal poverty level, who do not have insurance or are not fully covered by insurance, are eligible for the LLUMC-M Financial Assistance Policy (FAP). Eligibility includes patients with High Medical Costs.

2. Application. The LLUMC-M FAP uses a single Financial Assistance Application (FAA) for both Charity Care and Discounted Care. The single process gives each applicant an opportunity to receive the maximum financial assistance benefit for which they may qualify. Patients unable to demonstrate insurance coverage will be offered multiple opportunities to complete the FAA.

3. Application Process. To determine if Charity Care or Discounted Care can be granted, LLUMC-M will evaluate documentation received from patients who have completed an FAA. LLUMC-M's evaluation will include a review of health benefits coverage, family size, and either a tax return or recent pay stubs to establish qualification.

4. Government Sponsored Programs. LLUMC-M will offer uninsured patients information, assistance and referral to government sponsored programs for which they may be eligible such as Covered California, Presumptive Medi-Cal, or other programs. Local consumer legal assistance programs may also be available to help the uninsured patient with obtaining coverage.

5. **HELP PAYING YOUR BILL**

   5.1 **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**.

6. Charity Care and Discounted Care may be determined even after a patient account has been forwarded to an external agency for collection. If this occurs, the account will be returned to LLUMC-M by the collection agency.

7. LLUMC-M's evaluation of a FAA includes the review of:

7.1 Information necessary (family size and family income) to confirm financial assistance and eligibility; and

7.2 Documentation (tax return or recent pay stub) which confirm qualification for financial assistance; and

7.3 An audit trail documenting LLUMC-M's commitment to providing financial assistance.

8. A completed FAA is not required if LLUMC-M, in its sole discretion, determines it has sufficient patient financial information from which to make a financial assistance qualification decision. (See Section F. SPECIAL CHARITY CARE CIRCUMSTANCES)

C. QUALIFICATION: CHARITY CARE AND DISCOUNTED CARE

1. Qualification for Charity Care or Discounted Care financial assistance will be determined based on the patient's and/or guarantor's inability to pay using FPL criteria. Eligibility for financial assistance will not be based on age, gender, gender identity, sexual orientation, ethnicity, national origin, veteran status, disability, or religion. LLUMC-M retains full discretion, consistent with laws and regulations, to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.

2. Qualification of eligible patients may be determined at any time LLUMC-M is in receipt of a completed FAA and its supporting documentation.

3. LLUMC-M will provide assistance during registration to patients or their family representative to facilitate completion of the FAA. Completion of the FAA and submission of required supplemental information is required to establish qualification for financial assistance.

4. When emergency or urgent care visit charges are less than $5,000, LLUMC-M may reduce documentation requirements. In such cases, the patient or family representative may only be required to submit a completed and signed FAA. Tax returns or recent pay stubs may not be required in such cases. For charges that are $5,000 or more, LLUMC-M will require tax returns or recent pay stubs in addition to the completed and signed FAA.

5. Instructions for submission of supporting documents will be provided to the patient at the time a FAA is completed. The FAA and required supplemental documents are submitted to the Patient Business Office. The location of this office shall be clearly identified on the application instructions.

6. LLUMC-M shall provide personnel who have been trained to review FAAs for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient's need for a timely response.

7. Factors considered when determining whether an individual is qualified for financial assistance pursuant to this policy may include:

   7.1 Family income based upon federal income tax returns, recent pay stubs, or other relevant information that may be provided by the patient in the absence of said documents: and

   7.2 Family size

   7.3 No Monetary Assets are considered in making a qualification determination.

8. Financial Assistance qualification may be granted for Charity Care or Discounted Care depending on the patient or guarantor's level of qualification as defined in the criteria of this FAP. A financial assistance determination will be made only by approved LLUMC-M personnel according to the following levels of authority:

   8.1 Manager of Patient Business Office: Accounts less than $25,000

   8.2 Director of Patient Business Office: Accounts $25,000 - $50,000

   8.3 Asst. Vice President Business Office: Accounts $50,000 - $100,000

   8.4 Vice President, Revenue Cycle: Accounts greater than $100,000

9. Financial Assistance qualification will apply to the specific services and service dates for which application has been made by the patient and/guarantor. In cases of continuing care relating to a patient diagnosis which requires on-going, related services, LLUMC-M, at its sole discretion, may treat continuing care as a single case for which qualification applies to all related on-going services provided by LLUMC-M.

10. Patient obligations for Medi-Cal/Medicaid Share of Cost payments will not be waived under any circumstances. However, after collection of the patient Share of Cost portion, any non-covered or other unpaid balance relating to a Medi-Cal/Medicaid Share of Cost patient may be considered for Charity Care.

11. Patients whose income is 200% or less of the FPL receive full Charity Care and those patients between 201% and 400% of FPL will not pay more than what Medicare or Medi-Cal would typically pay, whichever is greater, for a similar episode of service. This shall apply to all medically necessary hospital inpatient, outpatient, recurring and emergency services provided by LLUMC-M.

12. FAP eligible patients will always be charged less than Gross Charges.

D. CHARITY CARE AND DISCOUNTED CARE INCOME QUALIFICATION LEVELS

UNINSURED PATIENT

1. If an uninsured patient's family income is 200% or less of the established poverty income level, based on current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, the patient qualifies for free Charity Care.

2. If the patient's family income is between 201% and 400% of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, the following Discounted Care assistance will apply:

   2.1 If the services are not covered by any third-party payer leaving the patient responsible for the full-billed charges, the patient's payment obligation will be a percentage of the amount the Medicare program would have paid for the service if the patient were a Medicare beneficiary. The actual percentage paid by a patient will be based on the sliding scale shown in Table 1 below:

TABLE 1

Sliding Scale Discount Schedule

Family Percentage of FPL	Discount off M/Care Allowable	Patient OOP Payment Percentage (of M/Care)
201 – 250%	75%	25%
251 – 300%	50%	50%
301 – 350%	25%	75%
351 – 400%	15%	85%

3. If the patient's family income is greater than 400% of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, the following Discounted Care assistance will apply:

3.1 If the services are not covered by any third-party payer leaving the patient/guarantor responsible for the full-billed charges, the total patient payment obligation will be an amount equal to 100% of the gross amount the Medicare program would have paid for the service if the patient were a Medicare beneficiary.

E. INSURED PATIENT

1. Except for Medi-Cal Share of Cost patients, when an insured patient's family income is 200% or less than the established poverty income level, based on current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, LLUMC-M will accept the amount paid by the third-party insurer and the patient will receive Charity Care assistance for their portion of payment and have no further payment obligation.

2. If an insured patient's family income is between 201% and 400% of the established poverty income level, based on current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, the following Discounted Care assistance will apply:

   2.1 For patient/guarantor payment obligations (e.g., a deductible or co-payment), the amount of the payment obligation will be equal to the difference between what insurance has paid and the amount Medicare would have paid if the patient were a Medicare beneficiary. If insurance has paid more than the Medicare allowable amount, the patient will owe nothing further, but if the patient's insurance has paid less than the Medicare allowable amount, the patient/guarantor will pay the difference between the insurance amount paid and the Medicare allowable amount.

3. If the patient's family income is greater than 400% of the established poverty income level, based on current FPL Guidelines, the following Discounted Care assistance will apply:

   3.1 For patient/guarantor payment obligations (e.g., a deductible or co-payment), the amount of the payment obligation will be equal to the difference between what insurance has paid and the gross amount that Medicare would have paid for the service, plus twenty percent (20%). For example, if insurance has paid more than the Medicare allowable amount plus 20%, the patient will owe nothing further; but if the patient's insurance has paid less than the Medicare allowable amount plus 20%, the patient will pay the difference between the insurance amount paid and an amount equal to the Medicare allowable amount plus 20%.

F. SPECIAL CHARITY CARE CIRCUMSTANCES

1. If the patient is determined by LLUMC-M Registration staff to be homeless and without third-party payer coverage, he/she will be deemed as automatically eligible for Charity Care.

2. In the case of a deceased patient, the patient's executor may provide information regarding an estate that may be subject to probate. If it is determined that no identifiable estate exists and no probate hearing is to occur, the patient's account shall be deemed automatically eligible for Charity Care.

3. Patients who have been declared bankrupt by a federal bankruptcy court order within the past twelve (12) months will be deemed eligible for Charity Care. The patient or guarantor must provide a copy of the court order document as part of their application.

4. Patients seen in the emergency department, for whom LLUMC-M is unable to issue a billing statement, may have the account charges written off as Charity Care (i.e., the patient leaves before billing information is obtained). All such circumstances shall be identified on the patient's account notes as an essential part of the documentation process.

5. Patients who have received hospital services, provided in good faith by LLUMC-M, may be deemed eligible for Charity Care when it is determined that it is not possible to bill any party due to the following circumstances:

   5.1 No health care coverage can be identified

   5.2 No contact information for the patient or guarantor can be confirmed (e.g., no known valid address, telephone, or other contact data)

   5.3 Mail has been returned

   5.4 A skip trace has been completed and no additional information has been developed enabling contact with the patient or guarantor

6. LLUMC-M deems those patients that are eligible for government sponsored low-income assistance programs (e.g., Medi-Cal/Medicaid, California Children's Services, and any other applicable state or local low-income program) to be automatically eligible for Charity Care when payment is not made by the governmental program. For example, patients who qualify for Medi-Cal/Medicaid as well as other government programs serving the needs of low-income patients (e.g., CHDP and some CCS) where the program does not make payment for all services or days during a hospital stay, are eligible for Financial Assistance coverage. Under LLUMC-M's FAP, these types of non-reimbursed patient account balances are eligible for full write-off as Charity Care. Specifically included as Charity Care are charges related to denied stays or denied days of care. All Treatment Authorization Request (TAR) denials provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income programs, and other denials (e.g., restricted coverage) are to be classified as Charity Care.

7. In waiving or reducing Medicare cost-sharing amounts, the hospital may consider the patient's monetary assets to the extent required for the hospital to be reimbursed under the Medicare program for Medicare bad debt without

seeking to collect cost-sharing amounts from the patient as required by federal law, including, but not limited to, Section 413.89 of Title 42 of the Code of Federal Regulations. Monetary assets include only assets that are convertible to cash and do not include retirement or deferred compensation plans qualified under the Internal Revenue Code, nonqualified deferred compensation plans, or assets below the maximum community spouse resource allowance under Section 1396r-5(d) of Title 42 of the United States Code.

These assets shall not be factored into an eligibility determination for Charity Care or Discounted Care, and the patient must otherwise qualify under the LLUMC-M financial assistance policy and then only to the extent of the write-off provided for under this policy.

8. Any uninsured patient whose income is greater than 400% of the current FPL and experiences a catastrophic medical event may be deemed eligible for financial assistance. Such patients who have higher incomes do not qualify for routine Charity Care or Discounted Care assistance. However, consideration of a catastrophic medical event may be made on a case-by-case basis. The determination of a catastrophic medical event will be based on the amount of patient liability at the time of billed charges, and consideration of the patient's income and assets as reported at the time of occurrence. Management will use reasonable discretion in making a determination based on a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds $200,000 may be considered for eligibility as a catastrophic medical event.

9. Any account returned to LLUMC-M from a collection agency that has determined the patient or guarantor does not have the resources to pay their bill may be deemed eligible for Charity Care. Documentation of the patient or guarantor inability to pay for services will be maintained in the Charity Care documentation file.

G. CRITERIA FOR RE-ASSIGNMENT FROM BAD DEBT TO CHARITY CARE

1. All outside collection agencies contracted with LLUMC-M to perform account follow-up and/or bad debt collection will adhere to the LLUMC-M FAP. All LLUMC-M collection agencies will have the LLUMC-M FAA and make them available to patients when account follow-up and/or bad debt collection efforts are made.

2. All outside collection agencies contracted with LLUMC-M to perform account follow-up and/or bad debt collection will utilize the following criteria to identify a status change from bad debt to Charity Care:

   2.1 Patient accounts must not have applicable insurance (including governmental coverage programs or other third-party payers) or the patient is substantially underinsured; and

2.2 The patient or guarantor must have a credit and/or behavior score rating within the lowest 25th percentile of credit scores for any credit evaluation method used; and

2.3 The patient or guarantor has not made a payment within 180 days of assignment to the collection agency; and

2.4 Attempts to communicate with the patient or guarantor by telephone and/or mail have been unsuccessful; and

2.5 The collection agency has determined that the patient/ guarantor has no visible means of making payment and is therefore unable to pay; and

2.6 The patient or guarantor does not have a valid Social Security Number and/or an accurately stated residence address to determine a credit score; and

2.7 The patient or guarantor does not possess real property; and

2.8 The address provided to the hospital by the patient or guarantor is incorrect, or was not provided; and

2.9 No employment and/or employer information is obtainable.

3. All account collection agents contracted by LLUMC-M will return bad debt accounts to LLUMC-M for reclassification as charity care when it has been determined the patient may be eligible for Charity Care or Discounted Care.

4. All accounts returned from a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by LLUMC-M Billing Department personnel prior to any re-classification within the hospital accounting system and records.

H. PATIENT NOTIFICATION

1. Once a determination of eligibility is made, a letter with the determination status will be sent to the patient or family representative. The determination status letter will state one of the following:

1.1 Approval: The letter will state the account has been approved, the level of approval and any outstanding amount owed by the patient. Information and directions for any further patient actions will also be provided.

1.2 Denial: The reasons for eligibility denial based on the FAA will be explained to the patient. Any outstanding amount owed by the patient will be identified. Contact information and instructions for payment will be provided.

1.3 Pending: The applicant will be informed as to why the FAA is incomplete. All outstanding information will be identified, and the notice will request that the information be supplied to LLUMC-M by the patient or guarantor.

I. QUALIFIED PAYMENT PLANS

1. When an approval determination for Discounted Care has been made by LLUMC-M, the patient will have the option to pay any or all outstanding amount due in one lump sum payment, or through a Qualified Payment Plan.

2. LLUMC-M will discuss payment plan options with each patient that requests to make arrangements for term payments. Individual payment plans will be arranged based on the patient's ability to effectively meet the payment terms. As a general guideline, payment plans will be structured to last no longer than 12 months.

3. LLUMC-M will negotiate in good faith with the patient; however, LLUMC-M has no obligation to accept the payment terms offered by the patient. If LLUMC-M and a patient or guarantor cannot reach an agreement to establish a Qualified Payment Plan, the hospital will establish a "reasonable payment plan".

4. No interest will be charged to qualified patient accounts for the duration of any payment plan arranged under the provisions of the FAP.

5. Once a payment plan has been approved by LLUMC-M, failure to make payments as outlined in the payment plan will constitute a payment plan default. It is the patient or guarantor's responsibility to contact the LLUMC-M Patient Business Office if circumstances change, and payment plan terms cannot be met. If a payment plan defaults, LLUMC-M will make a reasonable attempt to contact the patient or their family representative by telephone and give notice of the default in writing. The patient shall have an opportunity to renegotiate the payment plan and may do so by contacting a Patient Business Office representative within Fourteen (14) Days from the date of the written notice of payment plan default. If the patient fails to request renegotiation of the payment plan within Fourteen (14) Days, the payment plan will be deemed inoperative, and the account will become subject to collection.

6. All payment plans should be processed through an outside Electronic Funds Transfer (EFT) vendor. If a patient or family representative expresses a preference to have the payment plan processed without going through an outside EFT vendor, LLUMC-M may accommodate such requests if the patient makes payments via cash, check, money order or credit card.

J. DISPUTE RESOLUTION

1. If a dispute arises regarding Financial Assistance Program qualification, the patient may file a written appeal for reconsideration with LLUMC-M. The written

appeal should contain a complete explanation of the patient's dispute and reason for the request for reconsideration. Additional relevant documentation to support the patient's claim should be attached to the written appeal.

2. All appeals will be reviewed by the Assistant Vice President or Vice President of the Patient Business Office and will consider all written statements of dispute and any attached documentation. Upon completion of the review, patients will receive a written explanation of findings and the determination. All determinations by the Assistant Vice President or Vice President shall be final. There are no further appeals.

K. PUBLIC NOTICE

1. LLUMC-M will post notices informing the public of the FAP, the FAA, Public Notice, and the Billing and Debt Collection Policy. These notices will be posted in high volume inpatient and outpatient service areas of LLUMC-M, including but not limited to, the emergency department, billing office, inpatient admission and outpatient registration areas, outpatient observation units, or other common patient waiting areas of LLUMC-M. Notices will also be posted at any location where a patient may pay their bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for assistance.

    1.1 These notices will be posted in English and Spanish and are available in other languages as required by law.

    1.2 A tagline sheet in all required languages will be included with public notices to assure patient access.

2. Additionally, the Financial Assistance Policy, the Financial Assistance Application, and the Billing and Debt Collection Policy will be available online at Hospital Polices and Financial Assistance Application.

3. Paper copies of the above referenced documents will be made available to the public upon reasonable request at no additional cost. LLUMC-M will respond to such requests in a timely manner.

L. CHARITY DISCOUNT PAYMENT REPORTING

1. LLUMC-M will report the amount of Charity Care actually provided in accordance with Department of Health Care Access and Information (HCAi) rules contained in the Accounting and Reporting Manual for Hospitals, Second Edition. To comply with the regulation, LLUMC-M will maintain written documentation regarding its Charity Care criteria as well as documentation on all Charity Care determinations. As required by HCAi, Charity Care provided to patients will be recorded based on actual charges for services rendered.

2. LLUMC-M will provide HCAi with a copy of this FAP which includes the Charity Care and Discounted Care policies. The FAP also contains: 1) all eligibility and patient qualification procedures; 2) the unified application for charity care and discounted care; and 3) the review process for both charity care and discounted care. These documents will be supplied to HCAi every two years or whenever a significant change is made.

3. LLUMC-M will appoint an authorized primary and secondary contact to receive compliance and informational communications from HCAi. The two designated LLUMC-M personnel will register with HCAi. Any changes to the primary or secondary contacts will be communicated to HCAI within ten (10) working days.

4. LLUMC-M will appoint an authorized primary and secondary contact to review and respond to patient complaints. The two designated LLUMC-M personnel will register with HCAi. Any changes to the primary or secondary contacts will be communicated to HCAi within ten (10) working days.

M. OTHER

1. Confidentiality - It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy will be guided by these values.

2. Good Faith Requirements - LLUMC-M makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate. Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, or purposely inaccurate information has been provided by the patient or family representative. In addition, LLUMC-M reserves the right to seek all remedies, civil and criminal, from those patients or family representatives who have provided fraudulent or purposely inaccurate information to qualify for the LLUMC-M FAP.

3. LLUMC-M has established a Billing and Debt Collection Policy which is available online at Billing and Debt Collection Policy. All actions by LLUMC-M in obtaining credit information regarding a patient/responsible party or in connection with referring a patient/responsible party to an external collection agency will be consistent with the Billing and Debt Collection Policy.

APPROVERS: Executive Committee; LLUMC-M Board; LLUMC-M Chief Executive Officer; LLUMC-M Chief Financial Officer; LLUMC-M Hospital Cabinet; LLUMC-M Sr. VP/Administrator