LOMPOC VALLEY MEDICAL CENTER
Lompoc Healthcare District

Bad Debt, Charity and Discount Policy

Patient Financial Services

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Lompoc Valley Medical Center
Bad Debt, Charity Care/Discount Payment Policy

PURPOSE

The purpose of this policy is to define the criteria which will be used by Lompoc Valley Medical Center (LVMC) to comply with the requirements of the California Hospital Fair Pricing Policies Act.

California acute care hospitals must implement policies and practices that conform to California law, including requirements for written policies providing discounts and charity care to financially qualified patients. This policy is intended to meet such legal obligations and provides for both charity care and discounts to patients who financially qualify under the terms and conditions of the LVMC Charity Care/Discount Payment Policy.

SCOPE

This policy pertains to financial assistance provided to patients by LVMC. All requests for financial assistance from patients, patient families, physicians or hospital staff shall be addressed in accordance with this policy. This policy does not apply to physician services rendered at LVMC. However, emergency physicians at LVMC are required to maintain a separate policy that provides discounts to uninsured patients or patients with high medical costs whose income is at or below 400% of the Federal Poverty Level.

To help meet the needs of its patients, LVMC is committed to providing access to financial assistance programs when patients are uninsured or underinsured and may need help in paying their hospital bill. These programs include government sponsored coverage programs, charity care and discounted payment charity care as defined herein.

DEFINITION OF TERMS

Charity Care: Charity Care is defined as any medically necessary inpatient or outpatient hospital service provided to a patient who has an income below 200% of the current federal poverty level and who has established qualification in accordance with requirements contained in the LVMC Charity Care/Discount Payment Policy.

Discount Partial Charity Care Payment: Discount Payment through the Charity Care/Discount Payment Policy is defined as partial charity care which results from any medically necessary inpatient or outpatient hospital service provided to a patient who: 1) desires assistance with paying their hospital bill; 2) is uninsured or underinsured and has an income at or below 400% of the federal poverty level; and 3) who has established qualification in accordance with requirements contained in the LVMC Charity Care/Discount Payment Policy.

Qualified Payment Plan: Payment plans established by patients who have qualified for Discount Payment through the Charity Care/Discount Payment Policy are classified as a Qualified Payment Plan. A Qualified Payment Plan shall have no interest charges applied to any or all balances due from the patient/guarantor. In the event that LVMC and the patient/guarantor cannot reach agreement on terms for a qualified payment plan, the hospital shall use the formula described in Health & Safety Code Section 127400 (i), in order to establish terms for a "Reasonable payment plan," as defined in statute.

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

Patient with High Medical Costs: A patient who has health coverage and who also meets one of the following two criteria:

(a) Annual out-of-pocket costs incurred by the individual at the hospital exceed 10% of the
Patient's Family Income (defined below) in the prior 12 months; or
(b) Annual out-of-pocket medical expenses 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.

LVMC Charity Care/Discount Payment Policy Qualification Requirements: Depending upon individual patient qualification, LVMC financial assistance may be granted for charity care or discount partial charity care payment. If a person requests charity care or a discounted payment and fails to provide information that is reasonable and necessary for LVMC to make a determination, LVMC may consider that failure in making its determination. Financial assistance may be denied when the patient/responsible person does not meet the LVMC Charity Care/Discount Payment Policy qualification requirements.

Medically Necessary Services: Financial assistance under this policy shall apply to medically necessary services and not to those services that are primarily for patient comfort and/or patient convenience.

Patient's Family: The following shall be applied to all cases subject to the LVMC Charity Care/Discount Payment Policy:

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, whether living at home or not.

    a. Domestic Partner: A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division, and, at the time of filing, all of the following requirements are met:
        (1) Both persons have a common residence.
        (2) Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
        (3) The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
        (4) Both persons are at least 18 years of age.
        (5) Either of the following:
            (A) Both persons are members of the same sex.
            (B) One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62.
        (6) Both persons are capable of consenting to the domestic partnership.

2. For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

GENERAL PATIENT RESPONSIBILITIES

Patients must be honest and forthcoming when providing all information requested by LVMC as part of the financial assistance screening process. Patients are required to provide accurate and truthful eligibility documentation reasonably necessary for financial assistance coverage through any government coverage program or the LVMC Financial Assistance Program. Honesty implies and requires full and complete disclosure of required information and/or documentation.

All uninsured patients and those who request financial assistance will be required to complete a Financial Assistance Application. Prior to leaving LVMC, patients should verify what additional information or documentation must be submitted by the patient to LVMC. The patient shares responsibility for understanding and complying with the document filing deadlines of LVMC or other financial assistance programs.

Patients should expect and are required to pay any or all amounts due at the time of service. Said amounts due may include, but are not limited to:

- Co-Payments
- Deductibles
- Deposits
- Medi-Cal/Medicaid Share of Cost Amounts

The patient also shares a responsibility to assure that arrangements for settling the patient account have been completed. It is essential that each patient or their family representative cooperates and communicates with LVMC personnel during and after services are rendered.

HOSPITAL PROCESS and RESPONSIBILITIES

Eligibility under the LVMC Charity Care/Discount Payment Policy is provided for any patient whose family income is less than 400% of the current federal poverty level or Patient with High Medical Costs, if not covered by third party insurance or, if covered by third party insurance, which does not result in full payment of the account.

The LVMC Charity Care/Discount Payment Policy utilizes a single, unified patient application for both full charity care and discount payment. The process is designed to give each applicant an opportunity to receive the maximum financial assistance benefit for which they may qualify. The Financial Assistance Application provides patient information necessary for determining patient qualification by the hospital and such information will be used to qualify the patient or family representative for maximum coverage available through government programs and/or under the LVMC Charity Care/Discount Payment Policy.

Eligible patients may qualify for LVMC Charity Care/Discount Payment Policy by following application instructions and making every reasonable effort to provide LVMC with documentation and health benefits coverage information such that LVMC may make a determination of the patient's qualification for coverage under the appropriate program. Eligibility alone is not an entitlement to qualification under the LVMC Charity Care/Discount Payment Policy. LVMC must complete a process of applicant evaluation and determine qualification before full charity care or discount payment charity care may be granted.

The LVMC Charity Care/Discount Payment Policy relies upon the cooperation of individual patients who may be eligible for full or partial assistance. To facilitate receipt of accurate and timely patient financial information, LVMC will use a Financial Assistance Application. All patients unable to demonstrate financial coverage by third party insurers will be offered an opportunity to complete the Financial Assistance Application.

Uninsured patients will also: 1) be offered information, assistance and referral to government sponsored programs for which they may be eligible; and 2) provided information regarding insurance coverage through Covered California. Uninsured patients will also be provided contact information for local consumer legal assistance programs which may assist the uninsured patient with obtaining coverage.

Underinsured patients or Patient with High Medical Costs whose income is below 400% of the federal poverty level and who personally owe an amount after their insurance has paid may also be eligible for financial assistance. Any patient who requests financial assistance will be asked to complete a Financial Assistance Application.

The Financial Assistance Application should be completed as soon as there is an indication the patient 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.

Completion of a Financial Assistance Application provides:

1. Information necessary for LVMC to determine if the patient has income sufficient to pay for services;

2. Documentation useful in determining qualification for financial assistance; and

3. An audit trail documenting LVMC's commitment to providing financial assistance.

However, a completed Financial Assistance Application is not required if LVMC, in its sole discretion, determines it has sufficient patient financial information from which to make a financial assistance qualification decision.

LVMC PROCEDURES

Qualification: Full Charity Care and Discount Payment Charity Care

Qualification for full or discount payment financial assistance shall be determined solely by the patient's and/or patient family representative's ability to pay. Qualification for financial assistance shall not be based in any way on age, gender, sexual orientation,

gender identity, ethnicity, national origin, veteran status, disability or religion. While financial assistance shall not be provided on a discriminatory or arbitrary basis, LVMC 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.

It may be necessary for the patient and/or family representative to subsequently deliver supporting documentation to LVMC. Instructions for submission of supporting documents will be provided to the patient at the time a Financial Assistance Application is completed. The patient and/or patient family representative who requests assistance in meeting their financial obligation to LVMC shall make every reasonable effort to provide information necessary for LVMC to make a financial assistance qualification determination. The Financial Assistance Application and required supplemental documents are submitted to the Patient Business Office. The location of this office shall be clearly identified on the application instructions.

LVMC will provide personnel who have been trained to review Financial Assistance Applications for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient's need for a timely response.

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

1. Family income based upon federal income tax returns, recent pay stubs, or other relevant information provided by the patient in the absence of said documents; and
2. Family size

Financial Assistance qualification may be granted for charity care or discount payment depending upon the patient or family representative's level of qualification as defined in the criteria of this Charity Care/Discount Payment Policy.

A financial assistance determination will be made only by approved LVMC personnel according to the following levels of authority:

Director of Business Operations:	Accounts less than $10,000
Chief Financial Officer:	Accounts less than $25,000
Chief Executive Officer:	Accounts above $25,000

Once determined, Financial Assistance qualification will apply to the specific services and service dates for which application has been made by the patient and/or patient family representative. In cases of continuing care relating to a patient diagnosis which requires on-going, related services, LVMC, at its sole discretion, may treat continuing care as a single case for which qualification applies to all related on-going services provided by LVMC. Other pre-existing patient account balances outstanding at the time

of a qualification determination by LVMC will be included as eligible for write-off at the sole discretion of LVMC management

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.

Patients between 201% and 400% of FPL or Patient with High Medical Costs will not pay more than Medicare would typically pay for a similar episode of service. This shall apply to all medically necessary hospital inpatient, outpatient, recurring and emergency services provided by LVMC.

Full Charity and Discount Payment - Income Qualification Levels

Uninsured Patients

1. If an uninsured or High Medical Costs patient's family income is 200% or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, the patient qualifies for full charity care. Those with High Medical Costs, shall be eligible for charity care or discounted payments and shall not pay more than what the hospital would expect to receive from providing services to a government payor; these patients are eligible for up-to 100% Financial Assistance. Lompoc Valley Medical Center has sole discretion when determining a guarantor's status as being Medically Indigent.

2. If an uninsured 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 will apply:

    - If the services are not covered by any third party payer so that the patient ordinarily would be responsible for the full-billed charges, the patient's payment obligation will be the gross amount the Medicare program would have paid for the service if the patient were a Medicare beneficiary.

Insured Patients

1. If the patient's family income is *less 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 will apply:

- If the services received are covered by a third party payer such that the patient is responsible for only a portion of the billed charges (i.e., a deductible or co-payment), then the patient's payment obligation will be an amount equal to the difference between what insurance has paid and the gross amount that Medicare would have paid for the service if the patient were a Medicare beneficiary (i.e., 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 will pay the difference between the insurance amount paid and the Medicare allowable amount).

Special Charity Care Circumstances

1. If the patient is determined by LVMC Registration staff to be homeless and without third party payer coverage, he/she will be deemed as automatically eligible for charity care.

2. Deceased patients who do not have any third party payer coverage, an identifiable estate or for whom no probate hearing is to occur, shall be deemed automatically eligible for charity care.

3. Patients seen in the emergency department, for whom LVMC 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.

4. LVMC 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 programs) to be automatically eligible for full 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 LVMC's Charity Care/Discount Payment Policy, 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 and/or non-covered charges. All Treatment Authorization Request (TAR) denials provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income programs, other denials (e.g. restricted coverage) and non-covered charges are to be classified as Charity Care.

5. Any evaluation for financial assistance relating to patients covered by the Medicare Program must include a reasonable analysis of all patient assets, liabilities, income and expenses, prior to eligibility qualification for the Financial

Assistance Program. Such financial assistance evaluations must be made prior to service completion by LVMC.

- Notwithstanding the preceding, the portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payer including Medi-Cal/Medicaid, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as charity care if:

a. The patient is a beneficiary under Medi-Cal/Medicaid or another program serving the health care needs of low-income patients; or

b. The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

6. 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 full charity care or discount payment care. However, consideration of a catastrophic medical event may be made on a case-by-case basis. The determination of a catastrophic medical event shall be based upon the amount of the patient liability at billed charges, and consideration of the patient's income and assets as reported at the time of occurrence. Management shall use reasonable discretion in making a determination based upon a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds $45,000 may be considered for eligibility as a catastrophic medical event.

7. Any account returned to LVMC from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, may be deemed eligible for Charity Care. Documentation of the patient or family representative's inability to pay for services will be maintained in the Charity Care documentation file.

8. Patients who have insurance who refuse to provide sufficient information to their insurance carrier, resulting in the insurance carrier denying a claim for treatment, may not seek Financial Assistance for the costs of the denied care.
9. Patients who request that Lompoc Valley Medical Center not bill the patient's insurance carrier and who choose to pay for such services out-of-pocket as a self-pay patient may not seek Financial Assistance for the services paid out-of-pocket.

10. Financial assistance will be considered up to twelve (12) months from the date of service. The only exceptions would be patients who are denied for Disability Medicaid or when deemed appropriate by management. Financial assistance will also be applied to eligible accounts incurred for services received prior to the financial assistance application date.

Criteria for Re-Assignment from Bad Debt to Charity Care

All outside collection agencies contracted with LVMC 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:

1. Patient accounts must have no applicable insurance (including governmental coverage programs or other third party payers); and

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

3. The patient or family representative has not made a payment within 150 days of assignment to the collection agency;

4. The collection agency has determined that the patient/family representative is unable to pay; and/or

5. The patient or family representative does not have a valid Social Security Number and/or an accurately stated residence address in order to determine a credit score

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

Patient Notification

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

1. Approval: The letter will indicate 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.

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

3. Pending: The applicant will be informed as to why the Financial Assistance Application is incomplete. All outstanding information will be identified and the notice will request that the information be supplied to LVMC by the patient or family representative.

Qualified Payment Plans

When a determination of discount has been made by LVMC, the patient shall have the option to pay any or all outstanding amount due in one lump sum payment or through a scheduled term Qualified Payment Plan.

LVMC will discuss payment plan options with each patient that requests to make arrangements for term payments. Individual payment plans will be arranged based upon 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.

LVMC shall negotiate in good faith with the patient; however there is no obligation to accept the payment terms offered by the patient. In the event that LVMC and an individual patient or guarantor cannot reach an agreement to establish a Qualified Payment Plan, the hospital will use the "Reasonable payment plan" formula as defined in Health & Safety Code Section 127400 (i) as the basis for a payment plan. A "Reasonable payment plan" means monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses. In order to apply the "Reasonable payment plan" formula, LVMC shall collect patient family information on income and "Essential living expenses" in accordance with the statute. LVMC shall use a standardized form to collect such information. Each patient or guarantor seeking to establish a payment plan by applying the "Reasonable payment plan" formula shall submit the family income and expense information as requested, unless the information request is waived by representatives of LVMC.

No interest will be charged to Qualified Payment Plan accounts for the duration of any payment plan arranged under the provisions of the Charity Care/Discount Payment Policy.

Once a Qualified Payment Plan has been approved by LVMC, any failure to pay all consecutive payments due during a 90-day period will constitute a payment plan default. It is the patient or guarantor's responsibility to contact the LVMC Patient Business Office if circumstances change and payment plan terms cannot be met. However, in the event of a payment plan default, LVMC will make a reasonable attempt to contact the patient or their family representative by telephone and also give notice of the default in writing. The patient shall have an opportunity to renegotiate the extended Qualified 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 extended payment plan default. If the patient fails to request renegotiation of the extended payment plan within Fourteen (14) Days, the payment plan will be deemed inoperative and the account will become subject to collection.

Dispute Resolution

In the event that a dispute arises regarding Financial Assistance Program qualification, the patient may file a written appeal for reconsideration with LVMC. The written appeal

should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any or all additional relevant documentation to support the patient's claim should be attached to the written appeal.

Any or all appeals will be reviewed by the Director of Business Operations. The Director of Business Operations shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the Director of Business Operations shall provide the patient with a written explanation of findings and the determination. In the event that a dispute remains, a written appeal may be submitted to the Chief Financial Officer for secondary review. The written appeal must include relevant documentation to support the patient's claim of dispute. The Chief Financial Officer will review the information submitted by the patient and also the prior findings of the Director of Business Operations. All determinations by the Chief Financial Officer shall be final. There are no further appeals.

Public Notice

LVMC shall post notices informing the public of the Charity Care/Discount Payment Policy. Such notices shall be posted in high volume inpatient, and outpatient service areas of LVMC, including but not limited to, the emergency department, billing office, inpatient admission and outpatient registration areas or other common patient waiting areas of LVMC. Notices shall 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 such assistance.

These notices shall be posted in English and Spanish and any other languages that are representative of 5% or greater of patients in LVMC's service area.

A copy of this Charity Care/Discount Payment Policy will be made available to the public upon reasonable request. LVMC will respond to such requests in a timely manner.

Full Charity Care and Discount Payment Reporting

LVMC will report actual Charity Care provided in accordance with this regulatory requirements of the Office of Statewide Health Planning and Development (OSHPD) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. To comply with regulation, LVMC will maintain written documentation regarding its

Charity Care criteria, and for individual patients, LVMC will maintain written documentation regarding all Charity Care determinations. As required by OSHPD, Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.

LVMC will provide OSHPD with a copy of this Charity Care/Discount Payment Policy which includes the full charity care and discount payment policies within a single document. The Charity Care/Discount Payment Policy also contains: 1) all eligibility and patient qualification procedures; 2) the unified application for full charity care and

discount payment; and 3) the review process for both full charity care and discount payment. These documents shall be supplied to OSHPD every two years or whenever a significant change is made.

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 should be guided by these values.

Good Faith Requirements

LVMC 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, LVMC reserves the right to seek all remedies, civil and criminal, from those patients or family representatives who have provided fraudulent or purposely inaccurate information in order qualify for the LVMC Financial Assistance Program.

Credit and Collection Policy

LVMC has established a Credit and Collection Policy. All actions by LVMC in obtaining credit information regarding a patient/responsible party or in connection with referring a patient/responsible party to an external collection agency shall be consistent with the Credit and Collection Policy.

LVMC Credit & Collections

PURPOSE

Lompoc Valley Medical Center (LVMC) provides quality care to patients when they are in need of hospital services. All patients/responsible parties have a financial responsibility related to services received at Lompoc Valley Medical Center and must make arrangements for payment to LVMC either before or after services are rendered. Such arrangements may include payment by an insurance plan, including coverage programs offered through the federal and state government. Payment arrangements may also be made directly with the patient/responsible party subject to the payment terms and conditions of LVMC.

Emergency patients will always receive all medically necessary care within the scope of resources available at LVMC, to assure that their medical condition is stabilized prior to consideration of any financial arrangements.

This Credit and Collection Policy establishes the guidelines, policies and procedures for use by hospital personnel in evaluating and determining patient/responsible party payment arrangements. This policy is intended to establish a fair and effective means for collection of patient/responsible party accounts owed to the hospital. This Policy is to be used in conjunction with the Charity Care Policy which describes practices used during the inpatient admitting and outpatient registration processes. This Policy creates a linkage between information collected from patients/responsible parties at the front of the revenue cycle, and the billing and collections activities of the Patient Financial Services department.

SCOPE

This Policy will apply to all patients/responsible parties who receive services at LVMC. This policy defines the requirements and processes used by the LVMC Patient Business Office when making payment arrangements with individual patients/responsible parties. The Policy also specifies the standards and practices used by LVMC for the collection of debts arising from the provision of services to patients. The Policy acknowledges that some patients/responsible parties may have special payment arrangements as defined by an insurance contract to which LVMC is a party, or in accordance with hospital conditions of participation in state and federal programs. LVMC endeavors to treat every patient/responsible party with fair consideration and respect when making payment arrangements.

All requests for payment arrangements from patients, patient families, patient financial guarantors, physicians, hospital staff, or others shall be addressed in accordance with this policy.

POLICY

All patients who receive care at LVMC must make arrangements for payment of any or all amounts owed for hospital services rendered in good faith by LVMC. LVMC reserves the right and retains sole authority for establishing the terms and conditions of payment by individual patients/responsible parties, subject to requirements established under state and federal law or regulation.

GENERAL PRACTICES

1. LVMC and the patient/responsible party share responsibility for timely and accurate resolution of all patient accounts. Patient/responsible party cooperation and communication is essential to this process. LVMC will make reasonable, cost-effective efforts to assist patients/responsible parties with fulfillment of their financial responsibility.

2. Medical care at LVMC is available to those who may be in need of medically necessary services. To facilitate financial arrangements for persons who may be of low or moderate income, both those who are uninsured or underinsured, LVMC provides the following special assistance to patients/responsible parties as part of the routine billing process:

    a. A written statement of charges for services rendered by the hospital provided in a format which shows the patient a synopsis of all charges for services rendered. Upon patient/responsible party request, a complete itemized statement of charges will be provided;

    b. A written request that the patient/responsible party inform LVMC if the patient/responsible party has any health insurance coverage, Medicare, Medi-Cal or other form of insurance coverage;

    c. A written statement informing the patient/responsible party that they may be eligible for Medicare, Medi-Cal, California Children's Services Program, health plans available through Covered California or the LVMC Charity Care Program;

    d. A written statement indicating how the patient/responsible party may obtain an application for the Medi-Cal, health plans available through Covered California, or other appropriate government coverage program;

    e. If a patient/responsible party is uninsured, an application to the Medi-Cal, health plans available through Covered California, or other appropriate government assistance program will be provided. LVMC business associate is available at no cost to the patient to assist with application to relevant government assistance programs;

    f. A written statement regarding eligibility criteria and qualification procedures for full charity care and/or discount partial charity care under the LVMC Financial Assistance Program. This statement shall include the name and telephone number of hospital personnel who can assist the patient/responsible party with information about and an application for the LVMC Financial Assistance Program.

    g. Uninsured patients will also be provided contact information for local consumer legal assistance programs which may assist the uninsured patient with obtaining coverage.

3. The LVMC Patient Business Office is primarily responsible for the timely and accurate collection of all patient/responsible party accounts. Patient Business Office personnel work cooperatively with other hospital departments, members of the medical staff, patients/responsible parties, insurance companies, collection

agencies and others to assure that timely and accurate processing of patient/responsible party accounts can occur.

4. Accurate information provides the basis for LVMC to correctly bill patients/responsible parties or their insurer. Patient billing information should be obtained in advance of hospital services whenever possible so that verification, prior authorization or other approvals may be completed prior to the provision of services. When information cannot be obtained prior to the time of service, hospital personnel will work with each patient/responsible party to assure that all necessary billing information is received by LVMC prior to the completion of services.

PROCEDURES

1. Each patient/responsible party account will be assigned to an appropriate Patient Business Office representative based upon established criteria and staff workloads.

2. Once a patient/responsible party account is assigned to a Patient Business Office representative, the account details will be reviewed to assure accuracy and completeness of information necessary for the account to be billed.

3. If the account is payable by the patient's/responsible party's insurer, the initial bill will be forwarded directly to the designated insurer. LVMC Patient Business Office personnel will work with the patient's/responsible party's insurer to obtain any or all amounts owed on the account by the insurer. This will include calculation of contracted rates or other special arrangements that may apply. Once payment from the insurer has been determined by LVMC, any residual patient/responsible party liability balance, for example a co-payment or deductible amount, will be billed directly to the patient/responsible party. Any or all patient/responsible party balances are due and payable within 30 days from the date of this first patient/responsible party billing.

4. If the account is payable only by the patient/responsible party, it will be classified as a Self-pay account. Self-pay accounts may potentially qualify for government coverage programs, financial aid under the LVMC Charity Care Policy, or other policy discounts. Patients/responsible parties with accounts in Self-pay status should contact a Patient Business Office representative to obtain assistance with qualifying for one or more of these options.

5. In the event that a patient/responsible party has made a deposit payment, or other partial payment for services and it is subsequently determined that the patient qualifies for full charity care or discount payment, all deposits paid which exceed the payment obligation, if any, as determined through the Charity Care process, shall be refunded to the patient/responsible party with interest. Amounts owed

shall be reimbursed to the patient/responsible party within a reasonable time period. Interest shall begin to accrue on the first day that payment by the patient/responsible party is received by the hospital. Interest amounts shall accrue at Ten Percent (10%) per annum. In the event that the amount of interest owed to the patient/responsible party as part of a refund is less than Five Dollars ($5.00), no interest will be paid to the patient/responsible party.

6. All Self-pay accounts may be subject to a credit history review. LVMC will use a reputable, nationally-based credit reporting system for the purposes of obtaining the patient/responsible party's historical credit experience.

7. LVMC offers patients/responsible parties an extended payment plan option when they are not able to settle the account in one lump sum payment. Extended payment plans are established on a case-by-case basis through consideration of the total amount owed by the patient/responsible party to LVMC and the patient's/responsible party's financial circumstances. Extended payment plans generally require a minimum monthly payment of an amount such that the term of the payment plan shall not exceed twelve (12) months. Once an extended payment plan has been agreed to by the patient/guarantor, failure to make all consecutive payments due during any 60-day period will constitute a payment plan default. Written notice of extended payment plan default will be provided to the patient/guarantor. It is the patient/responsible party's responsibility to contact the LVMC Patient Business Office if circumstances change and payment plan terms cannot be met. Failure to do so may result in the account being forwarded to collection status.

8. Patients/responsible parties who have qualified for LVMC discounted partial financial assistance are eligible for a Qualified Payment Plan as described in the LVMC Charity Care/Discount Payment Policy. Qualified payment plans involve negotiation between the hospital and patient/responsible party and may result in a payment plan term which exceeds twelve (12) months. Qualified payment plans may be arranged by contacting a LVMC Patient Business Office representative. Qualified payment plans are free of any interest charges. Once a qualified payment plan has been approved by LVMC, any failure to pay all consecutive payments due during any 90-day period will constitute a payment plan default. It is the patient/responsible party's responsibility to contact the LVMC Patient Business Office if circumstances change and payment plan terms cannot be met. However, in the event of a payment plan default, LVMC will make a reasonable attempt to contact the patient/responsible party by telephone and also give notice of the default in writing. The patient/responsible party shall have an opportunity to renegotiate the extended 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 extended payment plan default. If the patient/responsible party fails to request renegotiation of the extended payment plan within Fourteen (14) Days, the payment plan will be deemed inoperative and the account may become subject to collection.

9. Patient/responsible party account balances in Self-pay status will be considered past due after 30 days from the date of initial billing. The Director of Business Operations or his/her designee shall implement procedures for compliance with the Charity Care/Discount Payment Policy. Accounts may only be advanced for collections that are in compliance with established procedures. Accounts may be advanced to collection status according to the following schedule:

    a. Any or all Self-pay account balances where it is determined by LVMC that the patient/responsible party provided fraudulent, misleading or purposely inaccurate demographic or billing information may be considered as advanced for collection immediately upon such a determination by LVMC.

    b. Any or all Self-pay account balances of less than three hundred ($300) where no payment has been received, and the patient/responsible party has not communicated with LVMC within 75 days of initial billing and a minimum of one bill showing details at the revenue code summary level and two cycle statements have been sent to the patient/responsible party.

    c. Any or all Self-pay account balances of greater than three hundred ($300) where no payment has been received, and the patient/responsible party has not communicated with LVMC, or its outsource business office representative within 90 days of initial billing and a minimum of one bill showing details at the revenue code summary level and two cycle statements have been sent to the patient/responsible party.

    d. Any or all other patient accounts, including those where there has been no payment within the past 60 days, may be forwarded to collection status when:
        i. Notice is provided to the patient/responsible party that payments have not been made in a timely manner and the account will be subject to collection 30 days from the notice date.
        ii. The patient/responsible party refuses to communicate or cooperate with LVMC Patient Business Office representatives; and

10. Patient/responsible party accounts will not be forwarded to collection status when the patient/responsible party makes reasonable efforts to communicate with LVMC Patient Business Office representatives and makes good faith efforts to resolve the outstanding account. The LVMC Patient Business Office representatives will determine if the patient/responsible party are continuing to make good faith efforts to resolve the patient/responsible party account and may use indicators such as: application for Medi-Cal, or other government programs; application for the LVMC Charity Care Program; regular partial payments of a reasonable amount; negotiation of a payment plan with LVMC and other such

indicators that demonstrate the patient's/responsible party's effort to fulfill their payment obligation.

11. After 30 days or anytime when an account otherwise becomes past due and subject to internal or external collection, LVMC will provide every patient/responsible party with written notice in the following form:

    a. **"State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at www.ftc.gov."**

    b. **Non-profit credit counseling services may be available in the area. Please contact the LVMC Patient Business Office if you need more information or assistance in contacting a credit counseling service.**

12. For all patient/responsible party accounts where there is no 3rd party insurer *and/or* whenever a patient/responsible party provides information that he or she may have High Medical Costs, the Patient Business Office representative will assure that the patient/responsible party has been provided all elements of information as listed above in number 2, General Practices, parts (a) through (g). This will be accomplished by sending a written billing supplement with the first patient/responsible party bill. The Patient Business Office representative will document that the billing supplement was sent by placing an affirmative statement in the "notes" section of the patient's/responsible party's account.

13. For all patient/responsible party accounts where there is no 3rd party insurer *and/or* whenever a patient/responsible party provides information that he or she may have High Medical Costs, LVMC will not report adverse information to a credit reporting agency or commence any civil action prior to 150 days after initial billing of the account. Furthermore, LVMC will not send an unpaid bill for such patients/responsible parties to an external collection agency unless the collection agency has agreed to comply with this requirement.

14. If a patient/responsible party has filed an appeal for coverage of services in accordance with Health & Safety Code Section 127426, LVMC will extend the 150 day limit on reporting of adverse information to a credit reporting agency

and/or will not commence any civil action until a final determination of the pending appeal has been made.

15. LVMC will only utilize external collection agencies with which it has established written contractual agreements. Every collection agency performing services on behalf of LVMC must agree to comply with the terms and conditions of such contracts as specified by LVMC. All collection agencies contracted to provide services for or on behalf of LVMC shall agree to comply with the standards and practices defined in the collection agency agreement; including this Credit and Collection Policy, the LVMC Charity Care Policy and all legal requirements including those specified in the California Health & Safety Code.

16. LVMC and/or its external collection agencies will not use wage garnishments or liens on a primary residence without an order of the court. Any or all legal action to collect an outstanding patient/responsible party account by LVMC and/or its collection agencies must be authorized and approved in advance, in writing by the LVMC Director of Business Operations and Chief Financial Officer. Any legal collection action must conform to the requirements of the California Health & Safety Code.

LVMC, its collection agencies, or any assignee may use any or all legal means to pursue reimbursement, debt collection and any enforcement remedy from third-party liability settlements, tortfeasors, or other legally responsible parties. Such actions shall be conducted only with the prior written approval of the LVMC Director of Patient Financial Services and the Chief Financial Officer