



LOMA LINDA UNIVERSITY  
MEDICAL CENTER – MURRIETA

# LOMA LINDA UNIVERSITY MEDICAL CENTER-MURRIETA

## OPERATING POLICY

<b>CATEGORY:</b>	FINANCE	<b>CODE:</b>	M-C-22
<b>SUBJECT:</b>	FINANCIAL ASSISTANCE	<b>EFFECTIVE:</b>	12/2022
		<b>REPLACES:</b>	02/2022
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### PURPOSE:

The purpose of this policy is to define the criteria which will be used by Loma Linda University Medical Center – Murrieta (LLUMC-M) to comply with the requirements set forth in state and federal laws, including section 501(r) of the Internal Revenue Code (IRC) of 1986, as amended, and the regulations there under and the California Hospital Fair Pricing Policies Act.

California acute care hospitals must implement policies and practices that conform to California law and IRC Section 501(r), 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 LLUMC-M Financial Assistance Policy (FAP).

### SCOPE OF POLICY:

This policy pertains to 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 shall be addressed in accordance with this policy. This policy does not apply to physician services rendered at LLUMC-M. The emergency physicians are not employed by LLUMC-M and have adopted a separate policy that provides 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 <https://medical-center.lomalindahealth.org/financial-assistance#LLUMC-M>).

### PHILOSOPHY:

As a faith-based organization, LLUMC-M strives to meet the health care needs of patients in its geographic service area. The LLUMC-M Mission is “To Continue the Healing Ministry of Jesus Christ and to Make Man Whole.” LLUMC-M’s Mission is expressly demonstrated through this FAP. The first and foremost responsibility of LLUMC-M is to see that its patients receive compassionate, timely, and appropriate medical care with consideration for patient privacy, dignity, and informed consent.

LLUMC-M regularly provides hospital services to patients who live locally in and around Murrieta. 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. These programs include government sponsored coverage programs, charity care and discounted payment charity care as defined herein.

In accordance with Federal Emergency Medical Treatment and Labor Act (EMTALA) regulations, LLUMC-M is prohibited from engaging in any actions that discourage individuals from seeking emergency medical care, such as demanding that emergency department patient's pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care.

#### DEFINITION OF TERMS:

##### Amount Generally Billed (AGB):

The Internal Revenue Service requires LLUMC-M to establish a methodology by which patients eligible for financial assistance will not be charged more than AGB for emergency and other medically necessary services. For purposes of this requirement, LLUMC-M adopts the prospective method based on Medicare rates.

##### 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 LLUMC-M FAP.

##### Discount Partial Charity Care Payment:

Discount Payment through the FAP is defined as partial charity care which results from any medically necessary inpatient or outpatient hospital service provided to a patient who is uninsured or whose insurance coverage does not otherwise provide a discount from the usual and customary rates of LLUMC-M; and 1) desires assistance with paying their hospital bill; 2) 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 LLUMC-M FAP.

##### 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.

##### Qualified Payment Plan:

Payment plans established by patients who have qualified for Discount Payment through the Financial Assistance 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 LLUMC-M 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.

Good Faith Estimate:

An amount quoted by LLUMC-M Registration staff that represents a reasonable approximation of the actual price to be paid for services received by the patient at LLUMC-M. 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).

International Services Department:

All international charity cases must be reviewed and approved by the International Charity Committee consistent with its annual budget criteria (reference Policy [International Benefit \(C-51\)](#)). Cases reviewed and approved by the Committee are not eligible for financial assistance through the FAP.

LLUMC-M Financial Assistance Policy Qualification Requirements:

Depending upon individual patient qualification, LLUMC-M 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 LLUMC-M to make a determination, LLUMC-M may consider that failure in making its determination. Financial assistance may be denied when the patient/responsible person does not meet the LLUMC-M FAP qualification requirements.

Medically Necessary Services:

Financial assistance under this policy shall apply to medically necessary services as defined by California Welfare & Institutions Code §14059.5. A service is medically necessary or a medical necessity when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Excluded from this definition are unique services where medically efficacious alternative therapies are available. Examples include: 1) Cosmetic and/or plastic surgery services; 2) Infertility services; 3) Vision correction; 4) Proton Therapy; 5) Robotic procedures; 6) Orthotics/Prosthetics; 7) Surrogate pregnancy; or 8) Other 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 LLUMC-M FAP:

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.

- 1.1 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:
- a. Both persons have a common residence.
  - b. 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.
  - c. The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
  - d. Both persons are at least 18 years of age.
  - e. Either of the following:
    - 1) Both persons are members of the same sex
    - 2) 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.
  - f. 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.

#### A. GENERAL PATIENT RESPONSIBILITIES

1. **To Be Honest:** Patients must be honest and forthcoming when providing all information requested by LLUMC-M 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 LLUMC-M FAP. Honesty implies and requires full and complete disclosure of required information and/or documentation.
2. **To Actively Participate and Complete Financial Screening:** All uninsured patients and those who request financial assistance will be required to complete a FAP. Prior to leaving LLUMC-M, patients should verify what

additional information or documentation must be submitted by the patient to LLUMC-M. The patient shares responsibility for understanding and complying with the document filing deadlines of LLUMC-M or other financial assistance programs.

3. To Pay Any or All Required Out-of-Pocket Amounts Due: 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:
  - 3.1 Co-Payments
  - 3.2 Deductibles
  - 3.3 Deposits
  - 3.4 Medi-Cal/Medicaid Share of Cost Amounts
  - 3.5 Good Faith Estimates
4. To Share Responsibility for Hospital Care: Each patient shares a responsibility for the hospital care they receive. This includes follow-up in obtaining prescriptions or other medical care after discharge. 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 LLUMC-M personnel during and after services are rendered.

## B. HOSPITAL PROCESS and RESPONSIBILITIES

1. Eligibility under the LLUMC-M FAP is provided for any patient whose family income is less than 400% of the current federal poverty level, if not covered by third party insurance or, if covered by third party insurance which does not result in full payment of the account.
2. The LLUMC-M FAP 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 (FAA) 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 LLUMC-M FAP.
3. Eligible patients may qualify and may apply for the LLUMC-M FAP by following application instructions and making every reasonable effort to provide LLUMC-M with documentation and health benefits coverage

- information such that LLUMC-M 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 LLUMC-M FAP. LLUMC-M must complete a process of applicant evaluation and determine qualification before full charity care or discount payment charity care may be granted.
4. The LLUMC-M FAP 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, LLUMC-M will use a FAA. All patients unable to demonstrate financial coverage by third party insurers will be offered an opportunity to complete the FAA.
  5. Uninsured patients will also be offered information, assistance and referral to government sponsored programs for which they may be eligible, and 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.
  6. Underinsured patients 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 FAA.
  7. The FAA 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.
  8. Completion of a FAA provides:
    - 8.1 Information necessary for LLUMC-M to determine if the patient has income sufficient to pay for services;
    - 8.2 Documentation useful in determining qualification for financial assistance; and
    - 8.3 An audit trail documenting LLUMC-M's commitment to providing financial assistance.
  9. However, 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 E. SPECIAL CHARITY CARE CIRCUMSTANCES)

C. QUALIFICATION: FULL CHARITY CARE AND DISCOUNT PAYMENT CHARITY CARE:

1. 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, gender identity, sexual orientation, ethnicity, national origin, veteran status, disability, or religion. While financial assistance shall not be provided on a discriminatory or arbitrary basis, 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. LLUMC-M shall provide direct assistance during registration to patients or their family representative to facilitate completion of the FAA. Completion of the FAA and submission of any or all required supplemental information may be required for establishing qualification for financial assistance.
3. Recognizing that LLUMC-M provides a high volume of lower acuity emergency and urgent care services to the local community, efforts are made to reduce the burden of application in certain cases. Although charges for emergency medical care can be quite high, such cases are less frequent than many other minor care visits. When the emergency or urgent care visit charges are less than \$5,000, 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. However, in the event charges exceed \$5,000, the patient or family representative must provide proof of income documents in the form of either a federal income tax return or copies of at least two recent pay stubs.
4. It may be necessary for the patient and/or family representative to subsequently deliver supporting documentation to LLUMC-M. Instructions for submission of supporting documents shall be provided to the patient at the time a FAA is completed. The patient and/or patient family representative who requests assistance in meeting their financial obligation to LLUMC-M shall make every reasonable effort to provide information necessary for LLUMC-M to make a financial assistance qualification determination. 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.
5. 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.

6. Factors considered when determining whether an individual is qualified for financial assistance pursuant to this policy may include:
  - 6.1 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
  - 6.2 Family size
7. 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 FAP. A financial assistance determination will be made only by approved LLUMC-M personnel according to the following levels of authority:
  - 7.1 Manager of Patient Business Office: Accounts less than \$50,000
  - 7.2 Director of Patient Business Office: Accounts less than \$100,000
  - 7.3 Asst. Vice President Business Office: Accounts less than \$250,000
  - 7.4 Vice President, Revenue Cycle: Accounts greater than \$250,000
8. 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, 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. Other pre-existing patient account balances outstanding at the time of a qualification determination by LLUMC-M will be included as eligible for write-off at the sole discretion of LLUMC-M management.
9. 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.
10. Patients between 201% and 400% of FPL 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 LLUMC-M.
11. FAP eligible patients will be charged less than Gross Charges.



**D. FULL CHARITY AND DISCOUNT PAYMENT - INCOME QUALIFICATION LEVELS UNINSURED PATIENT**

1. If an uninsured 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.
  
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 will apply:
  - 2.1 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 a percentage of the Medicare amount (fully loaded Medicare payment rate, i.e., wage index, IME, DME, etc., and patient payment obligation) the Medicare program would have paid for the service if the patient were a Medicare beneficiary. The actual percentage paid by any individual patient shall 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 will apply:
  - 3.1 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 total patient payment obligation will be an amount equal to 100% of the gross amount (fully loaded Medicare payment rate, i.e., wage index, IME, DME, etc., and patient payment obligation) the Medicare program would have paid for the service if the patient were a Medicare beneficiary.

## INSURED PATIENT

1. If an insured patient's family income is 200% or less than the established poverty income level, based upon 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 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 upon current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, the following will apply:
  - 2.1 For services received by patients 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 Medicare amount (fully loaded Medicare payment rate, i.e., wage index, IME, DME, etc., and patient payment obligation) of what Medicare would have paid 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).
3. If the patient's family income is greater than 400% of the established poverty income level, based upon current FPL Guidelines, the following will apply:
  - 3.1 For services received by patients 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, 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%.

## E. 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 full 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 full charity care.
3. Patients who have been declared bankrupt by a federal bankruptcy court order within the past twelve (12) months shall be deemed eligible for full charity care. The patient or family representative shall 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 full 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. Any patient who has 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:
  - A. No health care coverage can be identified
  - B. No contact information for the patient or guarantor can be confirmed (e.g., no known valid address, telephone, or other contact data)
  - C. Mail has been returned
  - D. 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 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 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. 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 LLUMC-M.
  - 7.1 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.
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 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 \$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 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.

#### F. 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 utilize the following criteria to identify a status change from bad debt to charity care:

- 1.1 Patient accounts must have no applicable insurance (including governmental coverage programs or other third-party payers) or the patient is substantially underinsured; and
  - 1.2 The patient or family representative must have a credit and/or behavior score rating within the lowest 25<sup>th</sup> percentile of credit scores for any credit evaluation method used; and
  - 1.3 The patient or family representative has not made a payment within 180 days of assignment to the collection agency; and
  - 1.4 Attempts to communicate with the patient or guarantor by telephone and/or mail have been unsuccessful; and
  - 1.5 The collection agency has determined that the patient/family representative has no visible means of making payment and is therefore unable to pay; and
  - 1.6 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; and
  - 1.7 The patient or guarantor does not possess real property; and
  - 1.8 The address provided to the hospital by the patient or guarantor is incorrect, or was not provided; and
  - 1.9 No employment and/or employer information is obtainable.
2. 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.

## G. PATIENT NOTIFICATION

1. 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:
  - 1.1 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.

- 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 also be identified. Contact information and instructions for payment will also 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 family representative.

#### H. QUALIFIED PAYMENT PLANS

1. When a determination of discount has been made by LLUMC-M, 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.
2. LLUMC-M shall 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.
3. LLUMC-M 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 LLUMC-M 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, LLUMC-M shall collect patient family information on income and "Essential living expenses" in accordance with the statute. LLUMC-M 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 LLUMC-M.
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, 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 LLUMC-M Patient Business Office if circumstances change and payment plan terms cannot be met. However, in the event of a payment plan default,

LLUMC-M 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 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.

6. Preferably, all payment plans should be processed through an outside electronic. Funds Transfer (EFT) vendor. In the event, however, the patient or family representative expresses a willingness to pay under a payment plan, without going through an outside EFT vendor, LLUMC-M will endeavor to accommodate such requests provided the patient pays the Extended Payment Plan via cash, check, money order or credit card.

#### I. DISPUTE RESOLUTION

1. In the event that 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 rationale for reconsideration. Any or all additional relevant documentation to support the patient's claim should be attached to the written appeal.
2. Any or all appeals will be reviewed by the Asst. Vice President of the Patient Business Office. The Asst. Vice President shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the Asst. Vice President shall provide the patient with a written explanation of findings and the determination. All determinations by the Asst. Vice President shall be final. There are no further appeals.

#### J. PUBLIC NOTICE

1. LLUMC-M shall post notices informing the public of the FAP, the FAA, the Plain Language Summary, and the Billing and Collection Policy. Such notices shall 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 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.

- 1.1 These notices shall be posted in English and Spanish and are available in other languages as required by IRC section 501(r).
2. Additionally, the Financial Assistance Policy, the Financial Assistance Application, the Plain Language Summary, and the Billing and Collection Policy shall be available online at <https://medical-center.lomalindahealth.org/financial-assistance#LLUMC-M>.
3. Paper copies of the above referenced documents shall be made available to the public upon reasonable request at no additional cost. LLUMC-M shall respond to such requests in a timely manner.

#### K. FULL CHARITY CARE AND DISCOUNT PAYMENT REPORTING

1. LLUMC-M shall report actual Charity Care provided in accordance with this regulatory requirements of the Department of Health Care Access and Information (HCAI) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. To comply with regulation, LLUMC-M will maintain written documentation regarding its Charity Care criteria, and for individual patients, LLUMC-M will maintain written documentation regarding all Charity Care determinations. As required by HCAI, Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.
2. LLUMC-M shall provide HCAI with a copy of this FAP which includes the full charity care and discount payment policies within a single document. The FAP 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 HCAI every two years or whenever a significant change is made.

#### L. 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 should 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 in order qualify for the LLUMC-M FAP.

3. Credit and Collection Policy - LLUMC-M has established a Billing and Collection Policy which is available online at <https://medical-center.lomalindahealth.org/financial-assistance#LLUMC-M>. 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 shall be consistent with the Credit and Collection Policy.

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