AVANTI HOSPITALS *MEMORIAL HOSPITAL OF GARDENA* *EAST L.A. DOCTORS HOSPITAL* *COMMUNITY HOSPTIAL OF HUNTINGTON PARK* *COAST PLAZA HOSPITAL* POLICY AND PROCEDURE	Subject: Charity Care	Item No.
	Scope: HOSPITALWIDE	No. of Pages: 13
Supersedes:	Approved by: CHIEF FINANCIAL OFFICER	
Effective: 5/30/2002	Date last revised: 01-01-2012 By: Rachel Gonzalez (CBO Director)	

PURPOSE:

To establish a policy for care that is rendered free of charge to individuals who, because of their financial status are unable to pay for services provided. This policy extends to all patients accepted by Avanti Hospital Systems. This policy is also intended to document MHG, ELA DOCTORS, CHHP & CHP compliance with Health & Safety Code requirements for written policies providing discounts to financially qualified patients, even though the policy obligations exceed such legal obligations and provide for discounts to patients who financially qualify.

SCOPE & RESPONSIBILITIES:

It is the responsibility of the CBO Director and the Admitting Managers to ensure that appropriate procedures, as described below, are in place and followed to ensure appropriate action is taken. This includes the handling of patient accounting transactions in a manner that supports the mission and values.

DETERMINATION/REVOKABILITY:

Charity Care eligibility can be determined, or revoked, at any point in the pre-admission, billing or collection process should any significant changes occur in the patient's financial status or third party coverage.

Policy

Full Charity Discount and Partial Charity Discount Defined

Full Charity Care is defined as writing off the bill of any necessary[1] inpatient, ER, UMS or outpatient hospital service provided to a patient who is unable to pay for care and who

[1] Necessary services are defined as any entity inpatient, outpatient, or emergency medical care that is not entirely elective for patient comfort and/or convenience.

has established qualification in accordance with requirements contained in the Avanti Hosptials Financial Assistance Policy.

Financial assistance by a partial discount is available against hospital charges for any necessary inpatient, ER, UMS or outpatient hospital services provided to a patient who is uninsured or underinsured and 1) who desires assistance with paying their hospital bill; 2) who can demonstrate that the patient has an income at or below 350% of the federal poverty level; and 3) who has established qualification in accordance with requirements contained in Avanti Hospitals Financial Assistance Policy.

Depending upon individual patient eligibility, financial assistance may be granted for full charity write-off or for a partial discount. Financial assistance may be denied when the patient or other responsible family representative does not meet the Avanti Hospitals Financial Assistance Policy requirements.

Full Charity and Partial Charity Discount Reporting

All Avanti hospitals located within California will report actual charity write-offs and discounts provided in accordance with regulatory requirements of the California Office of Statewide Health Planning and Development (OSHPD) as contained in the *Accounting and Reporting Manual for Hospitals, Second Edition*. To comply with regulation, each hospital will maintain written documentation regarding its criteria and, for individual patients, written documentation regarding all eligibility determinations. As required by OSHPD, charity discounts provided to patients will be recorded on the basis of actual charges for services rendered.

Each hospital will provide OSHPD with a copy of this Financial Assistance Policy which includes the full and partial discount policies within this single document. The Financial Assistance Policy also contains: 1) all eligibility and patient qualification procedures; 2) the unified application for full charity and partial charity discounts; and 3) the review process for both full charity care and discount partial charity care. These documents shall be supplied to OSHPD every two years or whenever a significant change is made.

Full and Partial Discount Eligibility: General Process and Responsibilities

Eligibility exists for any patient whose family[2] income is less than 500% of the current federal poverty level, and if not covered by third party insurance or if covered by third party insurance and unable to pay the patient liability amount owed after insurance has paid its portion of the account.

Avanti Hospitals Financial Assistance Program utilizes a single, unified patient application for both Full Charity and Partial Charity Discounts. The process to obtain assistance 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 the hospital to determine patient

[2] A patient's family is defined as: 1) For persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and 2) For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent of caretaker relative.

eligibility and such information will be used to qualify the patient or family representative for maximum coverage under the Avanti Hospitals Financial Assistance Program.

Eligible patients may qualify for Avanti Hospitals Financial Assistance Program by following application instructions and making every reasonable effort to provide the hospital with documentation and health benefits coverage information such that the hospital may make a determination of the patient's qualification for coverage under the program. Eligibility alone is not an entitlement to coverage under the Financial Assistance Program, but eligibility begins a process of evaluation to determine coverage before full charity or partial charity discounts may be granted.

Access to necessary care shall in no way be affected by whether financial assistance eligibility under this policy exists; medically necessary care will always be provided to the extent the facility can reasonably do so.

The Financial Assistance Program relies upon the cooperation of individual patients who may be eligible for full or partial assistance. To facilitate gathering accurate and timely patient financial information, a financial assistance application will be used. All patients unable to demonstrate financial coverage by third party insurers will be offered an opportunity to complete the financial assistance application, and will also be offered information, assistance and referral as appropriate to government sponsored programs for which they may be eligible. Insured patients who are unable to pay the bill remaining after insurance, or those who experience high medical costs may also be eligible for financial assistance. Any patient who requests financial assistance will be afforded the opportunity to complete a financial assistance application and have it considered.

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:

a. Information necessary for the hospital to determine if the patient has income sufficient to pay for services;

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

c. Documentation of the hospital's commitment to providing financial assistance.

However, a completed financial assistance application is not required if the hospital determines it has sufficient patient financial information from which to make a financial assistance qualification decision; an example of this can be a homeless patient.

Procedures

Qualification: Full Charity and Partial Charity Discounts

Qualification for full or partial financial assistance shall be determined without discrimination based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.

a. The patient and/or patient family representative who requests or is in need of financial assistance relative to the hospital bill shall make every reasonable effort to provide information necessary for the hospital to make a financial assistance qualification determination, and direct assistance shall be provided to patients or their family representative as necessary to help complete applications. Completion of the financial assistance application and submission of any or all required supplemental information may be required for establishing qualification for the Financial Assistance Program.

b. Financial Assistance Program qualification is determined after the patient and/or patient family representative establishes eligibility according to criteria contained in this policy. While financial assistance shall not be provided on a discriminatory or arbitrary basis, the hospital retains full discretion, consistent with laws and regulations, to establish objective eligibility criteria and determine when a patient demonstrates qualification for financial assistance.

c. Patients or their family representative who are provided an application for the Financial Assistance Program and who elect to complete it on their own shall be told of the availability of assistance to complete the application, where to turn in the application once complete, and what they can expect in follow-up.

d. Personnel who have been trained to review financial assistance applications for completeness and accuracy will review completed applications as quickly as possible and provide a timely response.

e. An affirmative financial assistance determination will be made only by approved hospital personnel according to the following levels of authority:

   Director of Patent Financial Services: Accounts less than $100,000.
   Chief Financial Officer: Accounts over than $100,000.

f. Factors to consider when determining whether an individual is qualified for financial assistance pursuant to this policy may include, but are not limited to:

   - Eligibility for insurance under any government coverage program or other third party insurer;
   - Family income (determined based upon tax returns and recent pay stubs);
   - Written verification of wages from employer
   - Copies of unemployment letters
   - Social Security checks
   - Disability Checks
   - EBT income
   - Signed Affidavits
   - Signed attestation stating patient is unemployed, or being supported by someone else.

- Family size
- Denial of coverage by governmental agency (Medicare, Medi-Cal, Healthy Families, CCS)

g. Qualification criteria are used in making each individual case determination for coverage under the Avanti Hospitals Financial Assistance Program. Financial assistance will be granted based upon each individual determination of financial need in accordance with the Financial Assistance Program eligibility criteria contained in this policy.

h. Financial assistance may be granted in full or in part depending upon the patient or family representative's level of eligibility as defined in the criteria of this Financial Assistance Program Policy.

i. Once qualification has occurred, the hospital may, at its sole discretion, treat continuing care as a single case for which qualification applies to all related on-going services provided by the hospital. Other pre-existing patient account balances outstanding at the time of a positive qualification may be eligible for write-off, but will be separately considered and may not be subject to this discount.

j. Patient obligations for Medi-Cal/Medicaid share of cost payments cannot be waived or discounted in advance under any circumstance. However, after collection of the patient share of cost portion, any other unpaid balance relating to a Medi-Cal/Medicaid share of cost patient may be considered for financial assistance.

k. Patients higher than 100% of the FPL will not be billed for more than the Medicare reimbursement rate tables that have been established by the hospital. This shall apply to all necessary hospital inpatient, outpatient and emergency services provided.

Full and Partial Charity Discount Income Qualification Levels

A charity care patient is a patient whose family income is below or equal to the charity care criteria (see below) and the first ten thousand ($10,000) of a patient's monetary assets shall not be counted in determining eligibility.

The 48 Contiguous States and DC

Persons in family	Poverty guideline
1	$11,170
2	15,130
3	19,090
4	23,050
5	27,010
6	30,970
7	34,930
8	38,890

For families with more than 8 persons, add $3,960 for each additional person.

2012 poverty scale

Example of the FA charity calculator is listed as Table 1:

a. If the patient's family income is 100% or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements ("Qualified at 100% FPL or less"), the entire (100%) patient liability portion of the bill for services will be written off.

b. Qualified at between 100.01% and 200% FPL, the following will apply:

   Patient's care is not covered by a payer. 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 bill will be discounted based on the Charity Care Financial Assistance Calculator (Medicare rate).

   Patient's care is covered by a payer. If the services are covered by a third party payer so that the patient is responsible for only a portion of the billed charges (i.e., a deductible or co-payment), the patient's payment obligation will not exceed the amounts calculated off the Charity Care Financial Assistance Calculator(Medicare rate).

c. Qualified at between 201% and 350% FPL, the following will apply:

   - Patient's care is not covered by a payer. 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[3] will be the hospital specific total gross amount based on the average HMO/PPO payment rate (the "Hospital Specific HMO/PPO Rate")[4].

   - Patient's care is covered by a payer. If the services are covered by a third party payer so that the patient is responsible for only the percentage of the total billed charges that would have been paid at the average Hospital Specific HMO/PPO Rate.

Payment Plans

A patient qualified for a partial discount shall have the option to pay any or all outstanding amount due in one lump sum payment, or through a scheduled term payment plan.

Payment plans are established on a case-by-case basis through consideration of the total amount owed by the patient to the individual Avanti hospital and the patient's or patient

[3] In the case of patient liability for co-payments or deductibles, this provision shall apply only when not expressly prohibited by any agreement between the Avanti hospitals and the patient's third party insurer.

[4] The average Hospital Specific Medicare/HMO/PPO payment is determined annually by the hospital, based upon all hospital Medicare/HMO/PPO payment rate amounts for inpatients and outpatients. Any patient liability amount due will be based upon calculation of the total gross payment obligation using the above methods.

family representative's financial circumstances. Payment plans generally require a minimum monthly payment of an amount such that the term of the payment plan term shall not exceed (12) months. Payment plans are free of any interest charges or set-up fees. Some situations may necessitate special payment plan arrangements based on negotiation between the hospital and patient or their representative. Payment plans may be arranged by contacting a Business Office representative or an outside agency that the hospitals have contracted with. Once a payment plan has been agreed upon, changes to it require the agreement of both parties. It is the patient's or guarantor's responsibility to contact the Business Office if circumstances change and payment plan terms cannot be met.

Special Circumstances

The following requirements must be satisfied to treat a patient as medically indigent for purposes of claiming Medicare bad debt pursuant to Medicare Provider Reimbursement Manual (PRM) § 310.

1. The patient's indigence must be determined by the provider, not by the patient. A patient's signed declaration of his inability to pay his medical is not proof of indigency.

2. The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash and unnecessary for the patient's daily living), liabilities, and income and expenses.

3. The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill.

4. The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

If the patient is determined to be homeless he/she will be deemed eligible for the Financial Assistance Program.

Patients seen in the emergency department, for whom the hospital is unable to issue a billing statement, may have the account charges written off. All such circumstances shall be identified on the patient's account notes as an essential part of the documentation process.

Other Eligible Circumstances

At any given time a patients financial status changes, they can be re-reviewed for financial assistance as long as all required documentation is received validating their financial status has changed. The hospital will make final determination of status upon new documentation submitted.

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

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 eligible for financial assistance if:

1. The patient is a beneficiary under Medi-Cal/Medicaid or another program serving the health care needs of low-income patients; or
2. 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.

Any patient who experiences a catastrophic medical event may be eligible for financial assistance. Patients who have high incomes do not qualify for routine full charity care or discount partial charity care. However, consideration as 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 individual's income and assets as reported at the time of occurrence. As a general guideline, any account with a patient liability for services rendered that exceeds $75,000 may be considered for eligibility as a catastrophic medical event.

Any services primarily designed to expand access to care for the medically poor may be considered eligible for financial assistance when the following conditions are met:

1. the services are identified in the hospital community benefit plan;
2. the services are targeted at populations which would qualify for financial assistance as identified within the community benefit plan;
3. the services are recorded at full established hospital rates as gross patient revenue;
4. the services are provided by a licensed healthcare professional; and
5. the services are those medical diagnostic or therapeutic services for which a medical record is maintained

Minimum payments may be accepted from patients to assist funding of access to care programs. Any or all self-pay patients may be offered a financial assistance screening form. However, any patient served through an access to care program shall be deemed as

qualified without absolute requirement for submission of a financial assistance application.

Any account returned to the hospital from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, will be considered for financial assistance. Documentation of the patient or family representative's inability to pay for services will be maintained

Criteria for Re-Assignment from Bad Debt to Charity Care

All outside collection agencies contracted with Avanti Hospitals 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).
2. The patient or family representative must have a credit 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; and
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 hospital personnel prior to any re-classification within the hospital accounting system and records.

Dispute Resolution

In the event that a dispute arises regarding qualification, the patient may file a written appeal for reconsideration with a complete explanation of the patient's dispute and rationale for reconsideration.

All appeals will be initially reviewed by the hospital director of patient financial services. The director shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the director shall provide the patient with a written explanation of findings and determination.

In the event that the patient believes a dispute remains after consideration of the appeal by the Centralized Business Office Director, the patient may request in writing, a review by the hospitals Administration Department. Administration shall review the patient's written appeal and documentation, as well as the findings of the CBO Director. The Administrative officer shall make a determination and provide a written explanation of findings to the patient. The internal dispute resolution process concludes with a final decision by the Administration Dept.

Public Notice

Each of the Avanti hospitals shall post notices informing the public of the Financial Assistance Program. Such notices shall be posting in high volume inpatient, and outpatient service areas of the hospital, including but not limited to the emergency department, billing office, inpatient admission and outpatient registration areas or other common patient waiting areas of the hospital. 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 the hospital's service area.

A copy of this Financial Assistance Policy will be made available to the public upon request, or on a reasonable basis.

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 Avanti Hospitals values and strive for such interactions to be sacred encounters.

Good Faith Requirements

Avanti Hospitals 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, Avanti hospitals reserves the right to seek all remedies, including but not limited to civil and criminal damages from those patients or family representatives who have provided fraudulent or purposely inaccurate information in order to qualify for Avanti's Financial Assistance Programs.

Table 1 – Example of FA Charity Calculator

East Los Angeles Doctors Hospital

Calculator for Financial Assistance/Charity Care

Account #
LAST, FIRST

Current Balance Due:

Total Household Member:

Total Annual Household Income:

Allowance
$10,000.00

Reimb %	Medicare	PPO/HMO
Inpatient	24%	35%
Outpatient	15%	20%
ER Visit	12%	15%

Range	From FPL%	To FPL %	Sliding Scale	Inpatient Amt Owed	Outpatient Amt Owed	ER Visit Amt Owed
	0.00	100.00	N/A	0.00	0.00	0.00
	100.01	200.00	N/A	0.00	0.00	0.00
	200.01	350.00	N/A	0.00	0.00	0.00

Table 2 – Example of FA Charity Application

EAST LOS ANGELES DOCTORS HOSPITAL
4060 E. Whittier Blvd.
Los Angeles, CA 90023

Community Hospital of Huntington Park
2623 E. Slauson Avenue
Huntington Park, CA 90255

Memorial Hospital of Gardena
1145 W. Redondo Beach Blvd.
Gardena, CA 90247

COAST PLAZA HOSPITAL
13100 Studebaker Road
Norwalk, CA 90650

EXHIBIT C

Patient Name_____	**Facility:**_____ **DOS:** _____	
Patient Number_____	**Confidential Financial Statement (Application)**	

RESPONSIBLE PARTY

Name	Marital Status	Social Security Number
Street Address, City, State, Zip	How long at this address	Home Phone
Employers Name and Address (If Unemployed –How Long)		Business Phone
Position / Title	Monthly income – Gross / Monthly income - Net	Length of current employment

SPOUSE

Name			Social Security Number
Employer Name and Address			Business Phone
Position / Title	Monthly income – Gross	Monthly income – Net	Length of current employment

DEPENDENTS

Name & Year of Birth of all dependents in household	Total Number of Dependents in household	Do Any Other Persons Contribute? If Yes, Amount: Yes/No Amount

INCOME PER MONTH & ASSETS

Dividends, Interest	$	Child Support / Alimony	$
Public Assistance / Food Stamps	$	Rental Income	$
Social Security	$	Grants	$
Unemployment Compensation	$	IRA	$
Workers' Compensation	$	Other	$
Savings	$		

EXPENSES PER MONTH

Mortgage / Rent Payment:	$ Balance: $	Medical / Dental	$
Own Home? (Yes/No)		Doctor – Name	$
Food	$	Doctor – Name	$
Utilities:	$	Doctor – Name	$
Electric	$	Credit Cards:	$
Gas	$	Visa Limit	$
Water / Sewer	$	Mastercard Limit	$
Trash	$	Discover Limit	$
Phone	$	Other Limit	$
Cable	$	Installment Loans	$
Auto Payments	$	Child Support	$
Auto Expenses	$	Miscellaneous Expenses	$
Insurance:			
Auto Premium	$		
Life Insurance	$		
Health Insurance	$		

OFFICE USE ONLY
Gross income_____
Net income_____
Total Expenses_____
Total Net income (loss)_____

To my knowledge the information provided above is true. I authorize a Credit Bureau Report to be secured by the Hospital or its agent to verify my financial standing.

_____ _____
PATIENT/GUARANTOR SIGNATURE DATE

Note: The Financial Statement (Application) is available in Spanish

Table 3 – Example of FA Charity Affidavit

EAST LOS ANGELES DOCTORS HOSPITAL
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Los Angeles, CA 90023

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2623 E. Slauson Avenue
Huntington Park, CA 90255

Memorial Hospital of Gardena
1145 W. Redondo Beach Blvd.
Gardena, CA 90247

COAST PLAZA HOSPITAL
13100 Studebaker Road
Norwalk, CA 90650

AFFIDAVIT

State of California
County of Los Angeles

I_____, living at

_____, Los Angeles County
California, certify through my signature that the statement given below is true and correct to the best of

My knowledge and belief: _____

SIGNATURE_____

ANY PERSON WHO SIGNS THIS STATEMENT AND WHO WILFULLY STATES IT AS TRUE AND MATERIAL MATTERS WHICH HE KNOWS TO BE FALSE IS SUBJECT TO THE PENALTIES PRESCRIBED FOR PERJURY IN THE PENAL CODE BY THE STATE OF CALIFORNIA; SEC.11054 OF THE W & J CODE.

WITNESSED AND VERIFIED BY _____ TITLE _____ DATE _____

East Los Angeles Doctors Hospital Campus
Centralized Business Office
4036 E. Whittier Blvd. Suite #100
Los Angeles, CA 90023
Office: (323) 318-8200 Fax: (323) 318-8239

Western Acute Care Physicians Medical Group, Inc.

COLLECTION OF DEBT POLICY

PURPOSE:

To define the process and procedures for the collection of debt, including the provision of financial relief to eligible patients through discounted Emergency Physician fees and the dissemination of information about available coverage and payment programs; to ensure compliance with Assembly Bill 1503 (2010).

DECLARATIONS:

The medical group (Group) is

Western Acute Care Physicians Medical Group, Inc.
2623 E. Slauson Avenue
Huntington Park, CA 90255

The hospital (Hospital) is

X Community Hospital of Huntington Park
2623 E. Slauson Avenue
Huntington Park, CA 90255

The current billing company (BC) is

Physicians' Choice, LLC
21860 Burbank Boulevard, Suite 120
Woodland Hills CA 91367
888-609-9988

The current collection agency (CA) is

CMRE Financial Services, Inc.
3075 East Imperial Highway, Suite 200
Brea, CA 92821
800-783-9118

The current database used for determination of discounted fees is

Decision Health
Physician Fee Schedule Benchmarks – Los Angeles, CA – Emergency Medicine
Based on 2009 billed services to Medicare

INTRODUCTION:

Western Acute Care Physicians Medical Group, Inc. (WACPMG or Group) provides emergency medical services at Community Hospital of Huntington Park (Hospital) in Huntington Park, California. The patients treated in the Emergency Department are billed for the services provided by the Group's billing company (BC). Most patients are covered under a form of medical insurance (Medicare, Medi-Cal, workers' compensation, PPO and HMO plans, etc.) and some are not. Frequently, insurance plans do not cover the entire cost of the care provided. In those cases, as well as instances where there is no coverage, a balance is due to the Group (debt).

Debt does not include adjustments including, but not limited to, Medicare, Medi-Cal, Knox Keene covered plans, Worker's Compensation, contracted plans, hardship cases, client requested adjustments, etc.

For insured or covered patients, debt may include, but is not limited to, deductibles, co-payments, co-insurance, non-covered services, etc.

For uninsured or self-pay patients debt will be the charge for the services provided.

Group will offer a discount to patients that request a discount and are eligible as defined below. Non-qualifying patients will be expected to pay their debt. Uncollected debt may be turned over to a collection agency.

POLICY:

1) Definitions:

(a) "Allowance for financially qualified patient," means, with respect to emergency care rendered to a financially qualified patient, an allowance that is applied after the Group's charges are imposed on the patient, due to the patient's determined financial inability to pay the charges.

(b) "Federal poverty level" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

(c) "Financially qualified patient" means a patient who is both of the following:

(1) A patient who is a self-pay patient or a patient with high medical costs.

(2) A patient who has a family income that does not exceed 350 percent of the federal poverty level.

(d) "Self-pay patient" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of

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(1) A patient who is a self-pay patient or a patient with high medical costs.

(2) A patient who has a family income that does not exceed 350 percent of the federal poverty level.

(d) "Self-pay patient" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of

workers' compensation, automobile insurance, or other insurance as determined and documented by the emergency physician, Group, Hospital or BC. Self-pay patients may include charity care patients.

(e) "A patient with high medical costs" means a person whose family income does not exceed 350 percent of the federal poverty level if that individual does not receive a discounted rate from the Group as a result of his or her third-party coverage.

For these purposes, "high medical costs" means any of the following:

(1) Annual out-of-pocket costs incurred by the individual at Hospital that exceed 10 percent of the patient's gross family income in the prior 12 months.

(2) Annual out-of-pocket expenses that exceed 10 percent of the patient's gross 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. The Group may waive the request for documentation.

(3) A lower level determined by the Group in accordance with the discounted payment policy of Hospital.

(f) "Patient's family" means the following:

(1) For patients 18 years of age and older, family would include spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not.

2) For patients under 18 years of age, family would include parent, caretaker relatives, and other children less than 21 years of age of the parent or caretaker relative.

2) Uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level shall be eligible to apply to the Group for a discount payment pursuant to this policy.

3) Notwithstanding any other provision of this policy, Group may choose to grant eligibility for a discount payment to patients with incomes over 350 percent of the federal poverty level.

4) Group shall limit expected payment for services provided to a patient who is eligible under this discount payment policy to an amount that is no greater than 50 percent of the average of billed charges of the nationally recognized database of physician and surgeon charges listed under Declarations in this policy. When FAIR Health, Inc. makes available the rate of payment received by physicians and surgeons from commercial insurers for the same services in the same or similar geographic region, the amount of expected payment under this section shall be no

greater than the median or average of rates paid by commercial insurers for the same or similar services in the same or similar geographic region.

5) Group may seek reimbursement from the Maddy Fund. If so, Group shall cease any further billing or collection activity for that patient. If Group does not attempt to seek reimbursement from the Maddy Fund, or if after attempting to obtain reimbursement from the Maddy Fund, Group is unsuccessful, it may again seek to receive payment from the patient in accordance with this debt collection policy.

6) A patient, or patient's legal representative, who requests a discounted payment or other assistance in meeting his or her financial obligation to the Group shall make every reasonable effort to provide the Group with documentation of income and health benefits coverage, if the Group requests said documentation. If the patient, or the patient's legal representative, requests a discounted payment and fails to provide information that is reasonable and necessary for the Group and its BC or CA to make a determination, the Group will consider that failure in making its determination.

7) For purposes of determining eligibility for discounted payment, the Group will primarily rely on the determination made by Hospital. If the Group chooses to make a separate determination of eligibility for discounted payment, or if the patient declines to participate in the Hospital's eligibility process, documentation of income shall be limited to recent income tax returns and in some cases recent pay stubs. Income tax returns will be used to determine the number of dependants in the family for the purpose of calculating the federal poverty level. The Group, at its sole discretion, may or may not accept self-attestation by a patient, or a patient's legal representative, but shall not request documentation of income other than that authorized in this paragraph. Information obtained pursuant to this paragraph shall not be used for collections activities. This paragraph does not prohibit the use of information obtained by the Group, BC or CA independent of the eligibility process for discounted payment. Eligibility for discounted payments may be determined by the Group at any time the Group is in receipt of the information described above.

8) Group shall make all reasonable efforts to obtain from the patient, or his or her representative, information about whether private or public health insurance or sponsorship may fully or partially cover the charges for emergency care rendered by Group to a patient, including, but not limited to, any of the following:

(a) Medicare

(b) Private health insurance, automobile insurance, or other third party payers.

(c) The Medi-Cal program, the Healthy Families Program, the California Children's Services Program, or other publicly funded programs designed to provide comprehensive health coverage.

9) Group through its BC shall bill patients who have not provided proof of coverage by a third party at the time the care is provided or upon discharge, and as a

part of that billing, Group shall provide the patient with a statement of charges for services rendered by the Group including the following notification at the bottom of the page:

> "If you are uninsured or have high medical costs, please contact our office at 800-460-1024 for information on discounts and programs for which you may be eligible, including the Medi-Cal program. If you have coverage, please tell us so that we may bill your plan."

10) For a patient that lacks coverage, or for a patient that provides information that he or she may be a patient with high medical costs, Group, BC, CA, or other owner of the patient debt, will not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after initial billing.

11) If a patient is attempting to qualify for eligibility under this policy and is attempting in good faith to settle an outstanding bill with the Group by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, Group, BC, or CA, will not report adverse information to a consumer credit agency.

12) In dealing with any patient covered under this policy, Group, BC, CA or any other assignee will not use as a means of collecting unpaid bills, any of the following:

> (a) A wage garnishment, except by order of the court upon noticed motion, supported by a declaration filed by the movant identifying the basis for its belief that the patient has the ability to make payments on the judgment under the wage garnishment, that the court shall consider in light of the size of the judgment and additional information provided by the patient prior to, or at, the hearing concerning the patient's ability to pay, including information about probable future medical expenses based on the current condition of the patient and other obligations of the patient.
>
> (b) Notice or conduct a sale of the patient's primary residence during the life of the patient or his or her spouse, or during the period a child of the patient is a minor, or a child of the patient who has attained the age of majority is unable to take care of himself or herself and resides in the dwelling as his or her primary residence. In the event a person protected by this paragraph owns more than one dwelling, the primary residence shall be the dwelling that is the patient's current homestead, as defined in Section 704.710 of the Code of Civil Procedure or was the patient's homestead at the time of the death of a person other than the patient who is asserting the protections of this paragraph.
>
> (c) This requirement does not preclude the Group, BC, CA, or other assignee from pursuing reimbursement and any enforcement remedy or remedies from third-party liability settlements, tortfeasors, or other legally responsible parties.

13) Group, BC, and CA shall offer extended payment plans that are reasonable and practical to assist patients eligible under this policy. Such payment plans will be interest free.

14) If the patient fails to make all consecutive payments due during a 90-day period, the extended payment plan will no longer be operative. Prior to declaring the that the payment plan is no longer operative, Group, BC, CA, or assignee shall make a reasonable attempt to contact the patient by telephone, if the telephone number is known, and give notice in writing that the extended payment plan may become inoperative, and of the opportunity to renegotiate the extended payment plan. Prior to cancellation of the plan, Group, BC, CA, or assignee shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. Group, BC, CA, or assignee will not report adverse information to a consumer credit reporting agency or commence a civil action against the patient or responsible party for nonpayment prior to the time the extended payment plan is declared to be no longer operative.

15) The 90 day period described in 14 will be extended if the patient has a pending appeal for coverage of the services, until a final determination of that appeal is made, if the patient makes a reasonable effort to communicate with Group, BC, CA, or assignee about the progress of any pending appeals. "Pending appeal" includes any of the following:

(a) A grievance against a contracting health care service plan, as described in Chapter 2.2 (commencing with Section 1340) of Division 2, or against an insurer, as described in Chapter 1 (commencing with Section 10110) of Part 2 of Division 2 of the Insurance Code.

(b) An independent medical review, as described in Section 10145.3 or 10169 of the Insurance Code.

(c) A fair hearing for a review of a Medi-Cal claim pursuant to Section 10950 of the Welfare and Institutions Code.

(d) An appeal regarding Medicare coverage consistent with federal law and regulations.

16) After the 90 day period described in 14 and 15, including any extension due to appeals, and prior to commencing further collection activities against a patient, Group, BC, CA, or assignee, will not report adverse information to a consumer credit reporting agency or commence a civil action, until the patient has been provided with a clear and conspicuous written notice containing both of the following:

(a) A plain language summary of the patient's rights pursuant to this article, the Rosenthal Fair Debt Collection Practices Act (Title 1.6C (commencing with Section 1788) of Part 4 of Division 3 of the Civil Code), and the federal Fair Debt Collection Practices Act (Subchapter V (commencing with Section 1692) of Chapter 41 of Title 15 of the United States Code). The summary shall include a statement that the Federal Trade Commission enforces the federal act. The summary shall be sufficient if it

appears in substantially the following form: "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 a.m. or after 9 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) A statement that nonprofit credit counseling services may be available in the area.

This notice will also accompany any document indicating that the commencement of collection activities may occur. The requirements described above shall apply to any entity engaged in reporting adverse information to a consumer credit reporting agency or commencing a civil action against the patient and will apply to any entity that Group assigns or sells its debt.

16) In the event that any patient makes a payment or payments in excess of the amount due under this policy, Group will reimburse the patient the amount actually paid in excess of the amount due plus interest.

17) Interest owed by Group to the patient shall accrue at the rate set forth in Section 685.010 of the Code of Civil Procedure (currently 10% per annum) beginning on the date payment by the patient is received by Group. However, no interest amount less than five dollars ($5) will be paid.

18) Group will require that its BC, CA and any other agent involved in the handling of Group debt agree in writing to adhere to the requirements of this policy and to any requirements imposed by Assembly Bill 1503 (2010).

AVANTI HOSPITALS: MEMORIAL HOSPITAL OF GARDENA EAST L.A. DOCTORS HOSPITAL COMMUNITY HOSPITAL OF HUNTINGTON PARK COAST PLAZA DOCTORS HOSPITAL	Subject: Self pay Discount Policy	Item No.
POLICY AND PROCEDURE	Scope: HOSPITALWIDE	No. of Pages: 2
Supersedes:	Approved by: Chief Financial Officer	
Effective: 01/01/2007	Date last revised: 01-01-2012	

Purpose:

Memorial Hospital of Gardena and East Los Angeles Doctors Hospital shall maintain a policy for Uninsured, Self-Pay patients to allow a 45% discount of Total Billed Charges.

Procedure:

1. Guidelines

- Patient must be uninsured.
- Account must be paid within 30 days for Final Bill date for total charges less 45% discount.
  Example: Total charges $100.00 – patient pays $55.00. Discount is $45.00.
- If patient is insured, patient must submit insurance information to the Centralized Business Office (CBO) department within 30 days from the discharge date. Billing after 30 days will be submitted to the payor(s) as a courtesy to the patient. The self-pay discount does will no longer apply, unless approved by CBO Director or Administraiton.
- If patient has an out-of pocket co-insurance or deductible, due to contractual Language restraints, Avanti Hospitals is not allowed to further discount unless patient qualifies for a Charity Care Adjustment. (See Financial Evaluation Guidelines Policy and Procedure).
- Any statement being generated to the patient may notate a 45% discount message will be given if paid in full within 30 days. If patient has insurance, patient is responsible to submit copy of front & back of their insurance card for billing within 30 days from discharge date.
- Centralized Business Office (CBO) will allow the Patient thirty (30) days from the Final Billed date to be approved for the discount. If payment is not received within this time frame, patient is responsible for total charges.

2. Control and Reporting Mechanisms:

- The Chief Financial Officer and/or CBO Director will denote specific financial or departmental criteria for which concurrent audits will be conducted.

- The CBO Director shall supervise the auditing, reporting and billing process involving appropriateness of self pay discounts.

- The CBO Director will review this policy annually for repeal or amendment.