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TORRANCE MEMORIAL MEDICAL CENTER

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Department: ADMINISTRATION

Policy/Procedure: **FINANCIAL ASSISTANCE POLICY**
Full Charity Care and Discount Partial Charity Care Policies

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PURPOSE

Torrance Memorial Medical Center (TMMC) is a non-profit organization which provides hospital services to the community of Torrance and the greater South Bay area of Southern California. Torrance Memorial Medical Center is committed to meeting the health care needs of all patients in the community, including those who may be uninsured or underinsured. As part of fulfilling this commitment, TMMC provides medically necessary services, without cost or at a reduced cost, to patients who qualify in accordance with the requirements of this Financial Assistance Policy. This policy defines the TMMC Financial Assistance Program; its criteria, systems, and methods.

California acute care hospitals must comply with Health & Safety Code 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 Torrance Memorial Medical Center Financial Assistance Program.

The Finance Department has responsibility for general accounting policy and procedure. Included within this purpose is a duty to ensure the consistent timing, recording and accounting treatment of transactions at TMMC. This includes the handling of patient accounting transactions in a manner that supports the mission and operational goals of Torrance Memorial Medical Center.

SCOPE

The Financial Assistance Policy will apply to all patients who receive services at TMMC. This policy pertains to financial assistance provided by Torrance Memorial Medical Center. All requests for financial assistance from patients, patient families, physicians or hospital staff shall be addressed in accordance with this policy.

Introduction

Torrance Memorial Medical Center strives to meet the health care needs of all patients who seek inpatient, outpatient and emergency services. TMMC 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 and charity care and discount partial charity care as defined herein.

The Charity Care Policy is applicable to all Emergency Room Physicians who provide emergency care at TMMC. All Emergency Room Physicians are contracted with TMMC and required to participate in the application of this policy as a condition of their contractual relationship with TMMC.

Full Charity Care and Discount Partial Charity Care Defined

Full Charity Care is defined as any necessary[1] inpatient or outpatient hospital service provided to a patient who is unable to pay for care and who has established qualification in accordance with requirements contained in the TMMC Financial Assistance Policy.

Discount Partial Charity Care is defined as any necessary inpatient or outpatient hospital service provided to a patient who is uninsured or underinsured and 1) desires assistance with paying their hospital bill; 2) has an income at or below 350% of the federal poverty level; and 3) who has established qualification in accordance with requirements contained in the TMMC Financial Assistance Policy.

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

Full Charity Care and Discount Partial Charity Care Reporting

TMMC will report actual Charity Care provided in accordance with 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, the hospital will maintain written documentation regarding its Charity Care criteria, and for individual patients, the hospital 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.

TMMC will provide OSHPD with a copy of this Financial Assistance Policy which includes the full charity care and discount partial charity care policies within a single document. The Financial Assistance Policy also contains: 1) all eligibility and patient qualification procedures; 2) the unified application for full charity care and discount partial charity care; 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.

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

Charity care will be reported as an element of the hospital's annual Community Benefit Report submitted to OSHPD and any other appropriate state agencies.

Full and Discount Eligibility: General Process and Responsibilities

Eligibility is defined for any patient whose family[2] income is less than 350% of the current federal poverty level, 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.

The TMMC Financial Assistance Program utilizes a single, unified patient application for both Full Charity Care and Discount Partial Charity Care. 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 under the TMMC Financial Assistance Program.

Eligible patients may qualify for the TMMC 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 TMMC Financial Assistance Program. TMMC must complete a process of applicant evaluation and determine coverage before full charity care or discount partial charity care may be granted.

The TMMC Financial Assistance Program 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, TMMC 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 be offered information, assistance and referral to government sponsored programs for which they may be eligible. Insured patients who are unable to pay patient liabilities after their insurance has paid, or those who experience high medical costs, 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:

[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.

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

- Documentation useful in determining qualification for financial assistance; and

- An audit trail documenting the hospital's commitment to providing financial assistance.

However, a completed financial assistance application is not required if TMMC determines it has sufficient patient financial information from which to make a financial assistance qualification decision.

PROCEDURES

Qualification: Full Charity Care and Discount Partial Charity Care

Qualification for full or discount partial 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, ethnicity, national origin, veteran status, disability or religion.

The patient and/or patient family representative who requests assistance in meeting their financial obligation to the hospital shall make every reasonable effort to provide information necessary for the hospital to make a financial assistance qualification determination. The hospital will provide guidance and/or direct assistance to patients or their family representative as necessary to facilitate completion of program 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.

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 eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.

Patients or their family representative may complete an application for the Financial Assistance Program. The application and required supplemental documents are submitted to the Patient Financial Services department at TMMC. This office shall be clearly identified on the application instructions.

If the patient or family has a pending application for another health coverage program while applying for financial assistance/charity care, the pending applicationfor other health coverage program shall not preclude eligibility for TMMC charity care.

TMMC 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.

A 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 greater than $100,001 and less than $250,000
President/CEO: Accounts greater than $250,001

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

- No insurance under any government coverage program or other third party insurer;
- Family income based upon tax returns and recent pay stubs
- Family size

Qualification criteria are used in making each individual case determination for coverage under the TMMC 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.

Financial Assistance Program qualification may be granted for full charity care (100% free services) or discount partial charity care (charity care of less than 100%), depending upon the patient or family representative's level of eligibility as defined in the criteria of this Financial Assistance Program Policy.

Once determined, Financial Assistance Program 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, the hospital, at its sole discretion, may 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 qualification determination by the hospital will be included as eligible for write-off at the sole discretion of management

Patient obligations for Medi-Cal/Medicaid share of cost payments will not be waived 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 Charity Care.

Patients at or below 350% of the FPL will not pay more than Medicare would typically pay for a similar episode of service. This shall apply to all necessary hospital inpatient, outpatient and emergency services provided by TMMC.

Full and Discount Partial Charity Care Income Qualification Levels

1. If the 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 Program qualification requirements, the entire (100%) patient liability portion of the bill for services will be written off.

2. If the patient's family income is between 201% and 350% of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, 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 payment obligation will be the gross amount the Medicare program would have paid for the service if the patient were a Medicare beneficiary.

    - 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 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. If the amount paid by insurance exceeds what Medicare would have paid, the patient will have no further payment obligation.

    - In either case, if a patient's responsibility is 10% or more of the patient's family income for the previous 12 months, the entire amount owed by the patient will be limited to 10% of their family income for the preceding 12 month period.

Payment Plans

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

The hospital 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 and shall take into account the patient's family income and essential living expenses. As a general guideline, payment plans will be structured to last no longer than 12 months. The hospital shall negotiate in good faith with the patient; however there is no obligation to accept the payment terms offered by the patient. If the hospital and patient or patient's family cannot agree to the terms of a payment plan, the monthly payment shall be based on 10% of the patient's family monthly income. No interest will be charged to the patient for the duration of any payment plan arranged under the provisions of the Financial Assistance Policy.

Special Circumstances

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 TMMC.

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 as Charity Care. All such circumstances shall be identified on the patient's account notes as an essential part of the documentation process.

Other Eligible Circumstances

TMMC deems 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) 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 as Charity Care. Specifically included as Charity Care 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 to be classified as Charity Care.

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:

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 whose income exceeds 350% of the FPL and experiences a catastrophic medical event may be deemed eligible for financial assistance. Such 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. 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 $100,000 may be considered for eligibility as a catastrophic medical event.

TMMC will make every reasonable, cost-effective effort to communicate payment options and programs with each patient who receives services at the hospital. In the event that a patient or guarantor does not respond or communicate with TMMC to resolve an open account, TMMC may forward the account to its collection agency. Since the financial status of the patient is not known, the amount forwarded for external collection will be discounted 81 % which shall be considered charity, if no other third party coverage is identified. The hospital's external collection agencies may adjust the amount further should the patient's financial status become known and the patient qualifies for financial assistance. The collection agency shall make efforts to collect only this reduced amount.

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, 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.

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 the hospital. 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 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 director of patient financial services, the patient may request in writing, a review by the Chief Financial Officer. The Chief Financial Officer shall review the patient's written appeal and documentation, as well as the findings of the Director of Patient Financial Services. The Chief Financial Officer shall make a determination and provide a written explanation of findings to the patient. All determinations by the Chief Financial Officer shall be final. There are no further appeals.

Public Notice

TMMC 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 outpatient 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 primary 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 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 these values.

Good Faith Requirements

TMMC 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, TMMC 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.

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Distributed to: Administrative Policy & Procedure Manual (Finance)

Related Policies:
Credit & Collection Policy – Admin 100.05
Discount Policy – Admin 100.06

TORRANCE MEMORIAL MEDICAL CENTER

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Department: ADMINISTRATION

Policy/Procedure: **CREDIT AND COLLECTION POLICY**

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PURPOSE

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

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

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

In addition, other TMMC policies such as the Financial Assistance Policy which contains provisions for full charity care and discount partial charity care will be considered by TMMC personnel when establishing payment arrangements for each specific patient or their guarantor.

SCOPE

FINANCIAL ASSISTANCE POLICY 100.04; PAGES 1-9,
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The Credit and Collection Policy will apply to all patients who receive services at Torrance Memorial Medical Center. This policy defines the requirements and processes used by the hospital business office when making payment arrangements with individual patients or their account guarantors. The Credit and Collection Policy also specifies the standards and practices used by the hospital for the collection of debts arising from the provision of services to patients at TMMC. The Credit and Collection Policy acknowledges that some patients may have special payment arrangements as defined by an insurance contract to which TMMC is a party, or in accordance with hospital conditions of participation in state and federal programs. TMMC endeavors to treat every patient or their guarantor 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 TMMC must make arrangements for payment of any or all amounts owed for hospital services rendered in good faith by TMMC. TMMC reserves the right and retains sole authority for establishing the terms and conditions of payment by individual patients and/or their guarantor, subject to requirements established under state and federal law or regulation.

GENERAL PRACTICES

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

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

    a. A written statement of charges for services rendered by the hospital provided in a revenue code summary format which shows the patient a synopsis of all charges by the department in which the charges arose. Upon patient request, a complete itemized statement of charges will be provided;
    b. Patients who have third party insurance will be provided a summary statement clearly showing the amount of payment expected from, or paid by insurance and any or all amounts due and payable by the patient. Upon patient request, a complete itemized statement of charges will be provided;
    c. A written request that the patient inform TMMC if the patient has any health insurance coverage, Medicare, Healthy Families, Medi-Cal coverage through the California Health Benefit Exchange, or other form of insurance coverage;

d. A written statement informing the patient or guarantor that they may be eligible for Medicare, Healthy Families, Medi-Cal, California Children's Services Program, the California Health Benefit Exchange, or the TMMC Financial Assistance Program;
e. A written statement indicating how the patient may obtain an application for the Medi-Cal, Healthy Families Program, the California Health Benefit Exchange, or other appropriate government coverage program;
f. If a patient is uninsured, an application to the Medi-Cal, Healthy Families Program or other appropriate government assistance program will be provided prior to discharge from the hospital;
g. A TMMC business associate is available at no cost to the patient to assist with application to relevant government assistance programs;

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

3. The TMMC Business Office is primarily responsible for the timely and accurate collection of all patient accounts. Business Office personnel work cooperatively with other hospital departments, members of the Medical Staff, patients, insurance companies, collection agencies and others to assure that timely and accurate processing of patient accounts can occur.

4. Accurate information provides the basis for TMMC to correctly bill patients 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 or their guarantor to assure that all necessary billing information is received by TMMC prior to the completion of services.

PROCEDURES

A. Each patient account will be assigned to an appropriate Business Office representative based upon the type of account payer and current individual staff workloads. The Business Office Director will periodically review staff workloads and may change or adjust the process or specific assignment of patient accounts to assure timely, accurate and cost-effective collection of such accounts.

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

C. If the account is payable by the patient's insurer, the initial bill will be forwarded directly to the designated insurer. TMMC Business Office personnel will work with the patient'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 by the insurer has been determined by TMMC, any residual patient liability balance, for example a patient co-payment or deductible amount, will be billed directly to the patient. Any or all patient balances are due and payable within 30 days from the date of this first patient billing.

D. If the account is payable only by the patient, it will be classified as a private pay account. Private pay accounts may potentially qualify for a prompt payment discount, government coverage programs, or financial aid under the TMMC Financial Assistance Policy. Patients with accounts in private pay status should contact a Business Office representative to obtain assistance with qualifying for one or more of these options.

E. All private pay accounts may be subject to a credit history review. Any private pay patient who is eligible for the TMMC Financial Assistance Program will not have a credit history review subsequent to a determination of program qualification. TMMC will use a reputable, nationally-based credit reporting system for the purposes of obtaining the patient or guarantor's historical credit experience.

F. TMMC offers patients a payment plan option when they are not able to settle the account in one lump sum payment. Payment plans are established on a case-by-case basis through consideration of the total amount owed by the patient to TMMC and the patient's or patient 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 twelve (12) months. This minimum monthly payment amount shall be determined by dividing the total outstanding patient liability balance by 12. 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. (See TMMC's Financial Assistance policy for payment plan details offered to patients with low incomes.)

   Payment plans may be arranged by contacting an TMMC Business Office representative. Once a payment plan has been approved, any failure to pay in accordance with the plan terms will constitute a plan default. It is the patient or guarantor's responsibility to contact the TMMC Business Office if circumstances change and payment plan terms cannot be met.

G. Patient account balances in private pay status will be considered past due after 30 days from the date of initial billing. Accounts may be advanced to collection status according to the following schedule:

   a. Any or all private pay account balances where it is determined by TMMC that the patient or guarantor provided fraudulent, misleading or purposely inaccurate

demographic or billing information may be considered as advanced for collection immediately upon such a determination by TMMC. Any such account will be reviewed and approved for advancement by the Business Office Director or her/his designee;

b. Any or all private pay account balances where no payment has been received, and the patient has not communicated with TMMC within 60 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 or guarantor may be advanced for collection. Any such account will be reviewed and approved for advancement by the Business Office Director or her/his designee;
c. 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 or guarantor 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 or guarantor refuses to communicate or cooperate with TMMC Business Office representatives; and
    iii. The Business Office Director or her/his management designee has reviewed the account prior to forwarding it to collection status.
d. Not withstanding the above, no private pay account previously set up on an extended payment plan under TMMC's Financial Assistance policy, for which there have been no payments for a consecutive 90 day time period, shall be forwarded to collection status or have further collection action taken until the following shall have occurred:
    i. The hospital or collection agency shall make a reasonable effort to contact the patient by phone and provide notice in writing that the payment plan may be declared inoperative.
    ii. The patient or patient's family shall be provided an opportunity to renegotiate the terms of the defaulted extended payment plan.

H. Patient accounts will not be forwarded to collection status when the patient or guarantor makes reasonable efforts to communicate with TMMC Business Office representatives and makes good faith efforts to resolve the outstanding account. The TMMC Business Office Director or her/his designee will determine if the patient or guarantor are continuing to make good faith efforts to resolve the patient account and may use indicators such as: application for Medi-Cal, Healthy Families or other government programs; application for the TMMC Financial Assistance Program; regular partial payments of a reasonable amount; negotiation of a payment plan with TMMC and other such indicators that demonstrate the patient's effort to fulfill their payment obligation.

I. After 30 days or anytime when an account otherwise becomes past due and subject to internal or external collection, TMMC will provide every patient 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 TMMC Business Office if you need more information or assistance in contacting a credit counseling service.**

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

K. For all patient accounts where there is no 3rd party insurer *and/or* whenever a patient provides information that he or she may have High Medical Costs, TMMC 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, TMMC will not send an unpaid bill for such patients to an external collection agency unless the collection agency has agreed to comply with this requirement.

L. If a patient or guarantor has filed an appeal for coverage of services in accordance with Health & Safety Code Section 127426, TMMC 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.

M. TMMC will only utilize external collection agencies with which it has established written contractual agreements. Every collection agency performing services on behalf of TMMC must agree to comply with the terms and conditions of such contracts as specified by TMMC. All collection agencies contracted to provide services for or on behalf of TMMC shall agree to comply with the standards and practices defined in the collection agency agreement; including this Credit and Collection Policy, the TMMC Financial Assistance Policy and all legal requirements including those specified in Health & Safety Code Sections 127400 and 127420 et seq.

N. Collection agencies may not commence charging interest on any account balance for any time period prior to the date the account was received by the collection agency. TMMC 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 account by TMMC and/or its collection agencies must be authorized and approved in advance, in writing by the TMMC Chief Financial Officer or his/her designee. Any such legal action must conform to the requirements of Health & Safety Code Section 127420 et seq.

O. TMMC, 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 hospital Director of Patient Financial Services or the Chief Financial Officer.

Initial Approvals & Major Revisions:

Initial Effective Date: 2/83

Reviewed/Revised Date(s): 8/85, 6/87, 7/89, 12/12/90, 9/93, 3/95, 2/97, 5/99, 11/01, 5/02, 01/12, 09/14

Board of Trustees: 2/27/91, 5/14/02, 9/24/03, 9/04, 12/05, 12/06, 05/09, 12/14
Operations Committee: 2/12/97, 7/02, 01/12, 09/14, 12/14

Distribution: Administrative Policy/Procedure Manual

TORRANCE MEMORIAL MEDICAL CENTER

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Department: **ADMINISTRATION**

Policy/Procedure: **DISCOUNT POLICY**

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PURPOSE

Torrance Memorial Medical Center (TMMC) provides compassionate care to patients when they are in need of hospital services. All patients or their guarantor have a financial responsibility for the hospital services they receive. Although TMMC strives to offer fair and competitive pricing for the services it provides, hospital care can still be very expensive.

There are many complex factors that determine how TMMC establishes charges for hospital service. TMMC recognizes that hospital charges may be difficult to understand in simple terms. To assist patients and their financial guarantors, the TMMC Discount Policy has been created to simplify the process of understanding how much each hospital visit will cost.

TMMC has developed a series of discounts from routine charges that will help reduce the cost of hospital services for patients who meet the payment terms and conditions for these price reductions. The Discount Policy establishes the guidelines, policies and procedures for use by hospital personnel when assisting patients or their financial guarantors with payment arrangements.

There are many government sponsored insurance programs which may provide coverage for patients who qualify. TMMC also maintains a Financial Assistance Policy that may provide additional help with payment for some low or moderate income patients. TMMC personnel will consider all appropriate options when establishing payment arrangements for each specific patient or their guarantor.

SCOPE

The Discount Policy applies to all patients who meet the terms and conditions as specified herein

and receive services at TMMC. The TMMC Business Office Director has the primary responsibility for implementation of the Discount Policy.

This policy defines the requirements and processes used by the hospital business office when making discounted payment arrangements with individual patients or their account guarantors. TMMC will endeavor to treat every patient or their guarantor with fair consideration and respect when making payment arrangements.

All requests for discount 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 TMMC must make arrangements for payment of any or all amounts owed to TMMC for hospital services rendered in good faith by the hospital. TMMC reserves the right and retains sole authority for establishing the terms and conditions of payment by individual patients and/or their guarantor, subject to requirements established under state and federal law or regulation.

Application of the Discount Policy does not require any type of individual patient or financial guarantor "means testing" as is required under the TMMC Financial Assistance Policy.

Any discount from routine hospital charges at TMMC is based upon consideration of applicable criteria for an individual qualified patient as established through this policy. Nothing in this Discount Policy shall be construed to prohibit TMMC from uniformly imposing charges from its established charge schedule or published rates. Furthermore, nothing herein shall be construed as a contravention to the TMMC uniform, published, prevailing or customary charges and fees available to the general public.

PROCEDURES

A. Prompt Payment Discount

Patients who are uninsured or do not have insurance coverage for the services requested are registered as "Private Pay," and may qualify for a substantial discount from TMMC's billed charges based upon prompt payment in full for all amounts owed to TMMC. The discount amount will be the greater of 81%, or the discount derived from the then as published "Procedural Fee Schedule for Private Pay Accounts". To qualify for the Prompt Payment Discount, the patient or patient's guarantor must make full and complete payment, at the reduced rate, for all amounts owed within 30 days from the date service. The Procedural Fee Schedule for Private Pay Accounts:

a. Is generally based upon similar payment arrangements with major insurance contractors;
b. Maintained in the Business Office and updated at a minimum, annually;
c. Will be applicable to all departments and services provided under this policy except as noted below;
d. May or may not include Hospital Based Physician Services (i.e., Pathology, Radiology, Anesthesiology, Radiation Oncology, or Emergency Physicians)
e. Will be the single source for provided "Cash Quotes" to the community.

B. Obstetrical Services Flat Rate Pricing

Patients who choose to deliver their baby at TMMC are offered a simple, flat rate or global price for those charges related to the admission for obstetric service. Patients must make arrangements for flat rate pricing in advance of their delivery date. Payment in full must be

received by TMMC prior to the delivery date.

C. **Elective Cosmetic Surgery Services**

Patients who choose to have elective plastic or cosmetic surgery services at TMMC are able to receive discounts on both hospital and anesthesia services. The patient's physician office must contact the surgery scheduling department in accordance with standard procedures to coordinate arrangements for elective plastic surgery services. Payment in full for the estimated amount due must be made in advance of the procedure. Additional amounts due, if any, must be made within 30 days of the service.

D. **Radiological Cash Pricing Services (CT, PET CT, MRI, etc.)**

Patients needing certain diagnostic imaging services at TMMC are able to receive discounts. The patient's physician office must contact the Financial Counselor or designated individuals in the Radiological department in accordance with standard procedures to coordinate arrangements for cash quotes for those services. Payment in full for the estimated amount due must be made in advance or at the time of the procedure. Additional amounts due, if any, must be made within 30 days of the service.

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Initial Approvals & Major Revisions:

Initial Effective Date: 1/1/2007
Reviewed/Revised Date(s):
Board of Trustees: 12/13/2007, 03/07, 05/09, 12/14
Operations Committee: 01/12, 09/14, 12/14

Distribution: Administrative Policy/Procedure Manual

Related Policies:
Financial Assistance Policy – Admin 100.04
Credit & Collection Policy – Admin 100.05