KECK HOSPITAL OF USC
USC NORRIS CANCER HOSPITAL
USC VERDUGO HILLS HOSPITAL
OPERATING POLICIES

MANUAL:	Patient Access	POLICY #:			
SUBJECT:	**Financial Assistance and Discount Policy**	EFFECTIVE DATE:			
		REVISED DATE:			
		AUTHORIZED APPROVAL:			
PERSONNEL COVERED:		PAGE:	1	OF	11

PURPOSE

To strive to be the trusted leader in quality health care that is personalized, compassionate and innovative for the patients we serve. Keck Medical Center (KMC), which encompasses Keck Hospital of USC, Norris Cancer Center and USC Verdugo Hills Hospital, is dedicated to research and clinical excellence and focused on improving the health care for the community we serve. We stand committed to help meet the needs of low-income uninsured, underinsured or patients with High Medical Costs as an important elem ent of our commitment to our community. This policy defines the means for KMC to demonstrate its long standing commitment to achieving its mission and values, and is compliant with all EMTALA policies and regulations. Keck and Norris hospitals do not have Emergency Departments and will appraise emergencies in accordance with hospital policies, including the Rapid Response Team and EMTALA Policies.

The Financial Assistance and Discount Policy (Policy) sets forth KMC's parameters regarding financial assistan ce or discounts for qualified patients. Further it is written in a form to direct and guide staff and communicate and administer the Policy for all patients who seek assistance in meeting their financial obligation for care. KMC will not deny emergency or other medically necessary care based on the ability to pay. The facility will not engage in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care. KMC does not offer Financial Assistance to patients that reside out the United States.

Hospital services do not include those services provided by The Keck School of Medicine of USC, USC Care or any independent physician. They bill separately for care provided. KMC does not control the financial assistance programs of any physician billing. If you are approved for financial assistance under KMC's Policy, please provide our approval letter to the physician(s) billing office for financial assistance consideration. This Financial Assistance policy does not cover any charges that are considered unrelated business income to the hospital.

POLICY

KMC will make every reasonable effort to identify and assist eligible patients in meeting their financial obligation to pay for hospital services. Financial assistance is designed to aid patients with demonstrated financial need and is not intended to supplement or circumvent third party coverage, including Medicare. Before a patient may be eligible under the Policy, all available resources must first be applied for, including, but not limited to, private health insurance (including coverage through California Health Benefit Exchange). Financial assistance information for KMC is widely publicized, both to the community at large and to KMC's patient population. Review can be facilitated through the use of interpreters (language, vision, and hearing) or written materials as requested by the individual. KMC will respect the dignity and privacy of any patient who requires assistance in meeting their financial obligation as described in the procedural sections below.

PROCEDURE

A. COMMUNICATION AND PATIENT/ACCOUNT IDENTIFICATION

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1. KMC widely publicizes its Policy through the following means:

    a. KMC makes the Policy, the financial assistance application, and a plain language summary of the Policy available on its Web site;

    b. KMC makes paper copies of the Policy, the financial assistance application, and a plain language summary available to patients or members of the community on request and without charge, both by mail and in the admissions areas of KMC and in Patient Accounting Customer Service. KMC has determined the percentage or number of LEP (limited English proficiency) individuals in the hospital facilities' community. KMC will provide these policies in English and Spanish languages based on Los Angeles Service Planning Area 4 which is the community served by KMC.

    c. KMC notifies and informs members of the community served by KMC of the Policy through the posting on KMC's Web site and through conspicuous posting in all locations with high patient volumes including, but not limited to, patient arrival locations, and check out areas, the billing office, and ancillary service locations. The Web site and the public postings inform patients where more information may be obtained.

    d. KMC notifies and informs individuals who receive care from KMC about the Policy by doing the following:

        1. Offering a copy of the plain language summary to patients as part of the intake or discharge process and providing written information about financi al assistance to all self-pay patients. This material includes a statement about how patients may obtain additional information;

        2. Including a conspicuous written notice on billing statements that (a) notifies recipients about the availability of discounted payment or charity care under the Policy, (b) includes the telephone number of Patient Financial Services department, which can provide additional information about the Policy and the application process, and also includes the direct Web site address where copies of the Policy, the financial assistance application, and the plain language summary of the Policy may be obtained; and (c) includes a statement that if a patient applies, or has a pending application, for another health coverage program at the sam e time that he or she applies for financial assistance from KMC, neither application shall preclude eligibility for the other.

        3. Posting conspicuous public displays that notify patients of the Policy in public areas of KMC, including the admissions areas and that also inform patients where they may obtain additional information.

        (Cal. Health & Safety Code § 127420(b); 26 U.S.C. § 501(r) —(4)(a)(5)).

2. Written materials regarding the Policy are available in English and Spanish. Language interpretive services are provided whenever necessary to facilitate the patient's understanding and participation in payment options for financial assistance.

3. Once a completed application is received, a financial assistance determination will be made as soon as reasonably possible. KMC personnel will make all reasonable efforts to obtain information from patients about whether private or public health insurance may fully or partially cover the expense of their care. KMC staff will assess the patient's eligibility for all available payer linkage options.

4. Patients' accounts for hospital services that may be appropriate for financial assistance include the following:

    e. Uninsured patients with no or limited means to pay.

    f. Insured patients who are unable to pay patient liabilities, e.g., deductibles, co-insurance, or co-pays, as required by third party coverage, including Medicare deductible or coinsurance and Medi-Cal Share of Cost.

    g. Patients with High Medical Costs as defined in definitions.

5. Patients that qualify will not be billed more than AGB (amounts generally billed) for emergency or medically necessary care. The Prospective Method will be used to determine AGB.

6. Amounts Generally Billed (AGB)Prospective Method: Amounts generally billed (AGB) is based on the billing and coding process KMC uses for Medicare fee-for-service for emergency or medically necessary services. Total expected payment from Medicare is divided by total expected billed charges for such claims, and that number is subtracted from 1 to calculate the AGB percentage. The KMC AGB reduction to gross charges is adjusted with any changes to charges. AGB% CALCULATION

B. FINANCIAL ASSISTANCE APPLICATION PROCESS

1. KMC personnel will assist any eligible patient unable to pay for services, who cooperatively provides information about his/her ability to pay. Failure to fully cooperate or complete the application entirely or provide requirement documentation will result in the application being denied under the Policy.

2. The financial assistance determination may be based on the patient providing individual or household income and family size information in the form of federal tax returns for the most recent year and, if employed, the two most recent pay stubs.

    a. The following additional information may be required:

        i. Information on all assets, both liquid and non-liquid, but shall not include statements on retirement or deferred-compensation plans;

        ii. Waivers or releases authorizing KMC to obtain account information from financial or commercial institutions that hold monetary assets to verify their value;

        iii. Family size (includes legally qualified dependents) used to determine the appropriate benchmark.

b. If it is determined that the family income is above 400% of the Federal Poverty Level (FPL), KMC may still consider the patient eligible for financial assistance but the following information may be required:

i. Individual or family net worth, including assets, both liquid and non-liquid, liabilities and claims against assets;

ii. Employment status will be considered in the context of whether the likelihood of future earnings will be sufficient to meet the cost of paying for healthcare services within a reasonable period of time;

iii. Unusual expenses or liabilities;

iv. Additional information as required for special circumstances.

3. Eligibility for financial assistance may be determined at any time KMC is in receipt of qualifying information. However, patients shall be encouraged to provide the information within 30 days of the request in order to partner with KMC during the billing cycle. The full collections cycle is for a 150-day period. During that time, KMC shall use monthly statements and out-bound calls to reach the patient regarding his or her obligation to provide the qualifying information and to continue to extend the offer of financial assistance under the Policy.

4. A patient's failure to engage in the collections cycle or submit a completed financial assistance application and required documents will result in the account(s) being placed with an external bad debt agency after 151 days in the billing cycle. This will include formal collections processes to collect on the balances due. We will not initiate ECAs until or after day 240 after the initial post discharge billing statement

C. FINANCIAL ASSISTANCE DETERMINATION AND ELIGIBILITY

1. To qualify for financial assistance coverage for either the entire hospital bill or a portion of the hospital bill, all of the following criteria must be met:

a. The patient must be a Self-Pay Patient or have documented annual out-of-pocket medical expenses that exceed 10% of the patient's family income in the prior 12 months;

b. The services are emergencies and/or medically necessary, not cosmetic;

c. The patient's family income does not exceed 400% of the FPL. (Cal. Health & Safety Code § 127400(c).

d. The individual must be a US resident and not an international patient who has traveled to the United States for the sole purpose of medical tourism.

2. The first $10,000.00 of a patient's monetary assets and 50% of a patient's monetary assets over the first $10,000.00 shall not be considered in determining eligibility for financial assistance.

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3. Financial assistance will be granted on a sliding scale basis, according to the Policy. The following eligibility requirements will be reviewed and updated annually. KMC's sliding scale:

FPL sliding Scale	**100%**	**133%**	**150%**	**200%**	**201%- 215%**	**216%- 230%**	**231%- 245%**	**246%- 260%**	**261%- 275%**	**276%- 290%**	**291%- 305%**	**306%- 320%**	**321%- 335%**	**336%- 349%**	**>350%**	**400%**
Discount%	**100%**	**100%**	**100%**	**100%**	**90%**	**80%**	**70%**	**60%**	**50%**	**40%**	**30%**	**20%**	**10%**	**5%**	**0%**	**0%**
Required Payment %	**0%**	**0%**	**0%**	**0%**	**10%**	**20%**	**30%**	**40%**	**50%**	**60%**	**70%**	**80%**	**90%**	**95%**	**100%**	**100%**

a. Both Self-Pay Patients and Patients with High Medical Costs are eligible to apply for the Discounted Payment Program.

(1) Self-Pay Patients**:** For Self-Pay Patients whose family income is between 201 percent and 350 percent, inclusive, of the FPL, KMC shall limit the expected payment for services provided by KMC to the amount of payment KMC would expect in good faith to receive for providing services under Medicare ("government-sponsored program rate"). If KMC provides a service for which there is no established payment by Medicare, then KMC shall establish an appropriate discounted payment amount.

(2) Patients with High Medical Costs: For Patients with High Medical Costs whose documented income is between 201 percent and 350 percent, inclusive, of the Federal Poverty Level, KMC shall limit the expected payment for services provided by KMC to the lesser of (i) the balance after any insurance payments are applied or (ii) the applicable government-sponsored program rate based on Medicare rates.

b. For an income level that is 200% of FPL or less, the entire hospital bill will be forgiven.

4. Patients who are determined to be Homeless or who qualify under Presumptive FA Eligibility (as defined below) and not participating in another financial assistance program will be granted 100% financial assistance.

5. All uninsured patients will be offered KMC's Established Cash Price for services rendered. If the patient's income is over 400% of the FPL, the patient will not automatically qualify for any additional write-off of the hospital bill. However, other considerations for eligibility may be made if the patient is unable to pay the Established Cash Price and at the discretion of the Associate Administrator of Revenue Cycle. These considerations include:

a. Presence of extenuating circumstances such as catastrophic medical events or other special situations. Any or all such cases require specific management approval. Net worth information included on the Patient Financial Assessment Statement will be used to evaluate these special situations;

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b. The presence of an applicable recent bankruptcy of the patient or third party providing coverage for the patient.

6. In determining the total amount an uninsured patient would be held responsible for if they only qualified for partial financial assistance, the Established Cash Price, not the total gross charges, will be used.

7. Circumstances where applications may not be required:

   a. Patients who have previously been identified as eligible for financial assistance may be granted financial assistance without repeating the full financial evaluation process for a period of six months.

8. A determination of eligibility will be made based on the all requested documentation.

9. Should it be determined that the patient has paid more than required, a refund will be issued.

10. Patients requesting to appeal financial assistance determinations may submit their requests to the Associate Administrator of Revenue Cycle.

D. ACCOUNT MANAGEMENT/NOTIFICATION REQUIREMENT

1. KMC posts the availability of this Policy at all locations with high patient volume, including admission and registration areas, outpatient settings and the Patient Account office.

2. KMC will provide patients with written notice containing information about availability of the Policy including information about eligibility, as well as contact information for additional information. This written notice also will be provided to patients who receive outpatient care and who may be billed for that care, but were not admitted as an inpatient.

3. KMC billing statements communicate the availability of government-sponsored programs for any patient who has not provided proof of coverage at the time of billing. KMC shall provide the following information with a patient's bill:

   a. A statement of charges for services provided by KMC;

   b. A request that the patient inform KMC if the patient has health insurance coverage, including Medicare, Healthy Families, Medi-Cal or other coverage;

   c. A statement indicating how patients may obtain applications for government-sponsored coverage and that KMC will provide these applications; and

   d. The KMC telephone number from which a patient may obtain information about KMC's Policy, and how to apply for financial assistance.

4. Each patient billing statement will include a prominent statement indicating the availability of financial assistance. The bill will also indicate the dates of hospital services and if a third party has been billed.

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5. Patient bills will include information about a KMC contact, including an address and telephone number patients may call when they have questions about their bill. Patient billing questions will be responded to promptly by telephone or in writing.

6. If the patient fails to engage in the collections cycle, and formal collections are required, KMC will follow all fair debt and collections practices according to this Policy and will act in a manner that treats patients with dignity, respect and compassion. Prior to formal collections, KMC will provide written notice containing:

    a. Nonprofit credit counseling services that may be available in the area;

    b. A plain language summary of the patient's rights pursuant to California Health and Safety Code Section 127430(a).

7. Accounts being evaluated for financial assistance will not be turned over to an internal or external collection agency until the conclusion of the financial assistance evaluation, which will occur in the event of the patient's failure to produce requested information or otherwise cooperate in pursuing financial assistance.

8. All collection activity will be based upon written procedures adhered to by both KMC collection staff and external collection agencies. A copy of the Billing and Collection Policy can be obtained from Patient Accounting Department or on our website keckmedicine.org/billing-collections-policy in multiple languages. We shall maintain an agreement with the external collection agency, requiring the agency to adhere to KMC's standards and scope of practices with respect to debt collection, and to comply with KMC's program of reasonable payment plans. The external collection agency will also assist the patient with the financial assistance program and application process. Any patient who qualifies under the financial assistance program will be removed from the external collection agency processing and any negative credit reporting will be deleted. Formal debt collections will be pursued in a consistent manner with state and federal collections laws.

9. Financial Assistance determination will be made only by approved Hospital personnel. In the event of a dispute, a patient or guarantor may seek review from the Associate Administrator of Revenue Cycle in writing by providing additional information to support the dispute at:

    Keck Medical Center of USC
    Attention: Associate Administrator of Revenue Cycle
    2011 N Soto Street
    Los Angeles CA 90033

10. Please send Financial Assistance Application and Required Documents to:
    Keck Hospital and Norris Cancer Hospital:
    - Contact the Financial Assistance Coordinator
    - Call: Keck 855-532-5729
      Norris 855-532-5729
    - Secure Fax for both Facilities: 323-865-5672
    - Mail: Keck Hospital of USC/Norris Cancer Hospital
      2011 N Soto Street
      Los Angeles CA 90033

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Verdugo Hills Hospital (VHH):

- Contact the Financial Assistance Coordinator
- Call: 818-949-4055
- Secure Fax: 818-949-4006
- Mail: Verdugo Hills Hospital (VHH)
  1812 Verdugo Blvd
  Glendale Ca 91208

E. PAYMENT PLANS FOR FINANCIALLY QUALIFIED PATIENTS WILL BE PROVIDED WITHOUT INTEREST CHARGES

1. A patient who qualifies for discounted payment shall cooperate in establishing an extended payment plan. KMC and the patient shall negotiate the terms of the payment plan and KMC shall take into consideration the patient's family income and Essential Living Expenses. If KMC and the patient cannot agree on an extended payment plan, then KMC shall create a reasonable payment plan based on amounts owed over time. A payment plan grid is established below and any deviation must be approved by the Associate Administrator of Revenue Cycle.

	Total Amount Owed and Months to Pay Based on Need		
Total Amount Owed	$1 to $500	$501 to $3,000	$3001+
May Be Approved by Staff	6 Months	12 Months	24 Months
Must Be Approved by Manager	12 Months	24 Months	36 Months

2. A payment plan will only be considered to be in default if a scheduled payment is not received for 90 days.

3. An attempt will be made to contact the patient both by phone and in writing before the payment plan is declared in default.

4. Defaulted payment plan accounts will be transferred to a formal collections process.

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DEFINITIONS

Charity Care	That portion of care provided by a hospital to a patient for which a third party payer is not responsible and the patient is unable to pay, and for which the hospital has no expectation of payment.
Discounted Payment	Limited, expected payment for emergency and medically necessary services to a discounted rate for financially qualified patients whose income is between 201 and 350%, inclusive, of the Federal Poverty Level.
Extraordinary Collection Action	Any action against an Individual(s) responsible for a bill related to obtaining payment of a Self-Pay Account that requires a legal or judicial process or reporting adverse information about the Responsible Individual(s) to consumer credit reporting agencies/credit bureaus. ECAs do not include transferring of a Self-Pay Account to another party for purposes of collection without the use of legal or judicial process or the reporting of adverse information to credit agencies/bureaus.
Essential Living Expenses	Expenses for any of the following: rent or house payment and maintenance; food and household supplies; utilities and telephone; clothing; medical and dental payments; insurance; school or child care; child and spousal support; transportation and auto expenses, including insurance, gas and repairs; installment payments; laundry and cleaning; and other extraordinary expens es
Established Cash Price	The expected payment amount after the application of a discount from its full charges for services offered to patients who have no insurance or qualify under the hospital's discount payment policy.
Federal Poverty Level	The most recent poverty guidelines periodically adopted by the federal Department of Health and Human Services for determining financial eligibility for participation in various programs based upon family size as applicable to California.
Homeless	A person is Homeless if he/she lives: 1. In a place not meant for human habitation such as: streets, cars, abandoned buildings, parks; 2. In emergency shelters; 3. In transitional or supportive housing (for people coming from the street or a shelter) and;

4. In any of the above places, but is in a hospital/institution short-term (30 days or less);

5. In a private dwelling, but will be evicted within a week;

6. In an institution, but will be discharged within a week and the discharging institution does not provide housing as part of discharge planning;

7. Without a secure living environment because the patient is a victim of domestic violence;

8. Without any possible residence having been identified and with no resources nor support networks to assist with obtaining housing.

Source: www.HUD.gov offices

http://www.dmh.co.la.ca.us/Hah/documents/COUNTRYS_3_%20Homelessness_%20Eligibility_%20Doc_Guide.pdf#search=%22defining%20homelessness%22

Income — Includes, but is not limited to, wages, salaries, Social Security payments, public assistance, unemployment and workers' compensation, veterans' benefits, child support, alimony, pensions, regular insurance and annuity payments, income from estates and trusts, assets drawn down as withdrawals from a bank, sale of property or liquid assets and one-time insurance or compensation payments.

Medically Necessary Services — A medically necessary service or treatment is one that is absolutely necessary to treat or diagnose a patient and could materially adversely affect the patient's condition, illness or injury if it were omitted, and is not considered an elective or cosmetic surgery or treatment.

Patient — For the purpose of this Policy, Patient refers to the individual seeking services or the individual responsible financially for services. Keck Medical Center defines the guarantor as the patient unless mentally incapacitated or a minor.

Patient with High Medical Costs — Patient who meets *all* of the following requirements:

1. A patient with third party coverage (i.e., not a Self-Pay Patient);

2. A patient whose family income does not exceed 350 percent of the Federal Poverty Level; and

3. A patient whose annual out-of-pocket costs incurred by the individual at KMC exceed 10 percent of the patient's family income in the prior 12 months; *or* whose annual out-of-pocket medical expenses exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

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Presumptive FA Eligibility

KMC recognizes that a portion of the uninsured or underinsured patient population may not engage in the traditional financial assistance (FA) application process. If the required information is not provided by the patient, KMC utilizes an automated, predictive scoring tool to qualify patients for Charity Care. The PARO™ tool predicts the likelihood of a patient to qualify for Charity Care based on publicly available data sources. PARO provides estimates of the patient's likely socio-economic standing, as well as, the patient's household income and size.

Self-Pay Patient

A patient who meets the following criteria:

1. No third party insurance;
2. No Medi-Cal or other government-sponsored program; and
3. No coverage under Workers Compensation, automobile insurance, or other insurance as determined and documented by KMC.

REFERENCES

Internal Revenue Code of 1986, Section 501(r).

Effective/Revision Dates for Policy # <insert policy number>		
Effective:	00/00/0000	<replace with revising committeename>
Revised:	00/00/0000	
	00/00/0000	
	00/00/0000	
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