Memorial Health Services **Policies and Procedures**	**Effective Date: February 01, 2016**
Subject: Financial Assistance	**Approval Signature:** **Barry Arbuckle** **President & CEO**
Manual: Finance/Purchasing **Policy/Procedure # 236**	**Sponsor Signature:** **Toni Upton** **Vice President** **Patient Financial Services**

PURPOSE:

The purpose of this Policy is to set forth the process for providing financial assistance for care provided by Memorial Health Services (MHS) hospitals to patients who have limited or no means to pay the full billed charges for their care.

SCOPE

This Policy is applicable to each wholly-owned MHS hospital.

DEFINITIONS:

Financial Assistance Program means MHS's financial assistance program available to patients unable to pay for their care for any services provided by an MHS hospital.

Charity Care means the Financial Assistance Program discount of 100% of the patient liability for services provided by an MHS hospital.

Low Income Financial Assistance (LIFA) means the Financial Assistance Program discount reducing a portion of the patient liability for services provided by an MHS hospital.

Federal Poverty Level (FPL) 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.

POLICY:

MHS offers financial assistance to qualified low-income patients unable to pay for services provided by an MHS owned and operated hospital, to the extent that the hospital services provided are not covered or reimbursed by any state or federal government program (including Medicare, Medi-Cal, or county indigent programs) or any other third party payer. Eligibility for financial assistance will be evaluated in accordance with the requirements contained in this Policy. Depending upon individual patient eligibility, financial assistance may be granted on a full or partial aid basis. Financial assistance may be denied when the patient or other financially-

responsible party does not meet the Financial Assistance Program requirements. References to a “patient” in this Policy include the party who is financially responsible, if applicable.

Regardless of a patient’s ability to pay or eligibility under this Policy, MHS hospitals will provide emergency medical care to all individuals to the extent the MHS hospital is reasonably able to do so.

PROCEDURE:

A. Eligibility Requirements

1. Uninsured patients or patients with high medical costs (as defined below) whose income is at or below 350% of the FPL and who receive services provided by an MHS hospital shall be eligible to apply for participation under the Financial Assistance Program. “High medical costs” means (1) annual out-of-pocket costs incurred by the patient at the MHS hospital that exceed 10% of the patient’s family income in the prior 12 months; or (2) annual out of pocket expenses that exceed 10% of the patient’s family income, if the patient provides documentation of the patient’s medical expenses paid by the patient or the patient’s family in the prior 12 months.

2. Patients with pending applications for a government-sponsored health coverage program are also eligible to apply for the Financial Assistance Program.

3. Eligibility for financial assistance shall be determined solely by the patient’s ability to pay, and shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.

B. Financial Assistance Qualification

Financial assistance will be granted based upon individual determination of financial need. Following a determination of qualification under the Financial Assistance Program, a patient will not be charged more for hospital services than the amounts generally billed to individuals who have insurance covering such services.

1. Charity Care

a. Eligible patients will qualify for Charity Care if both of the following requirements are met, in addition to all other Financial Assistance Program qualification requirements:

i. The patient’s household income is at or below 138% of the current FPL guidelines; and

ii. The patient’s monetary assets are not sufficient to pay for the services rendered.

b. Monetary assets include assets that are readily convertible to cash. Monetary assets do not include the following:

i. Primary residence

ii. One vehicle per patient or two vehicles per family unit

iii. The first $10,000 of monetary assets, and 50% of monetary assets after the first $10,000

iv. Retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans

c. Documentation of the patient's income will be limited to recent pay stubs or income tax returns. Evaluation of the patient's monetary assets will take into account both the asset value and amounts owed against the asset to determine if potential net worth is available to satisfy the patient payment obligation. The patient may be required to authorize the MHS hospital to obtain account information from financial or commercial institutions, or other entities that hold monetary assets, to verify their value.

d. Any patient who refuses to disclose their assets will automatically be ineligible for Charity Care but may still qualify for LIFA.

2. Low Income Financial Assistance

a. Eligible patients will qualify for LIFA if the following requirements are met, in addition to all other Financial Assistance Program qualification requirements:

i. The patient's household income is at or below 350% of the current FPL guidelines; and

ii. The patient does not qualify for Charity Care.

b. For the purpose of determining whether a patient qualifies for LIFA, documentation of the patient's income shall be limited to recent pay stubs or income tax returns. Assets will not be considered.

c. If the services are not covered by a third party payer, the LIFA-qualified patient's payment obligation will be 100% of the total expected payment (including co-payment and deductible amounts) that the Medicare program would have paid for the service if the patient was a Medicare beneficiary, or 40% of billed charges if the service provided is not covered under the Medicare program.

d. If the services are covered by a third-party payer, and the LIFA-qualified patient is responsible for only a portion of billed charges, the patient's payment obligation will be the difference of:

i. 100% of the total expected payment (including co-payment and deductible amounts) that the Medicare program would have paid for the service if the patient was a Medicare beneficiary, and

ii. the third-party payer's payment for the services.

3. Household income includes the income of the patient, the patient's spouse, any individual to whom the patient is a dependent and any other individual legally responsible to provide for the patient's health care needs. At age 18, a patient's income will be considered separately, regardless of living arrangements, unless the hospital is informed that the patient is still a dependent.

4. If the patient has third-party insurance which would have covered the hospital services, the patient is responsible for complying with the conditions of coverage for their health insurance. Failure to do so, when the patient could have reasonably complied, may result in a denial of qualification under the Financial Assistance Program.

5. In the event services are covered by Medi-Cal, the patient's copayment responsibility may not be waived under any circumstance. However, after collection of the patient responsibility portion, any other unpaid balance relating to a Medi-Cal patient may be considered for financial assistance.

C. Applying for Financial Assistance

1. Patients may apply for financial assistance from an MHS hospital by submitting a completed Financial Assistance Program application. The Financial Assistance Program application form may be submitted prior to service, during a patient stay, or after services are completed and the patient has been discharged. In general, a Financial Assistance Program application will not be accepted if submitted more than 240 days after the initial post-discharge billing, except as otherwise provided by 26 C.F.R. §1.501(r)-(6)(c). Each MHS hospital will provide assistance with completion of an application for the Financial Assistance Program as needed and will also provide guidance and/or direct assistance to patients as necessary to facilitate completion of government low-income program applications when the patient may be eligible.

2. As part of the Financial Assistance Program application, the patient must provide the following:

    a. Submission of all requested information and documentation necessary for the MHS hospital to determine if the patient has household income (including a certified income tax return or paystubs) and/or monetary assets sufficient to pay for the services; and

    b. Authorization for the MHS hospital to obtain a credit report for the patient or responsible party.

3. Financial Assistance Program qualification is determined after the patient establishes eligibility according to criteria contained in this Policy. The MHS hospital's determination of whether a patient qualifies for financial assistance under the Financial Assistance Program will occur only after sufficient information has been provided to MHS. MHS retains full discretion to establish Financial Assistance Program criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance. In the event of a dispute regarding eligibility or qualification for financial assistance, a patient may submit a written request for

reconsideration to the Vice President of the MHS Patient Financial Services Department (PFS).

4. Patients applying for financial assistance will be mailed a written notice approving or denying financial assistance within 10 business days from the date PFS receives a completed application with all necessary documentation.

5. MHS relies on the fact that information presented by the patient 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, inaccurate or incomplete information has been given. In addition, the MHS hospital reserves the right to seek all remedies, including but not limited to civil and criminal damages from those who have provided false, inaccurate or incomplete information in order to qualify for the Financial Assistance Program.

6. It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. MHS hospital personnel will maintain the confidentiality of all requests, information and funding for patients who seek or receive financial assistance.

7. Once qualification for the Financial Assistance Program is determined, such determination will remain in effect for a period of 6 months. After 6 months, the patient will need to reapply for consideration under the Financial Assistance Program and the MHS hospital will determine if the patient continues to qualify for financial assistance upon the patient's submission of information reasonably required by the MHS hospital. Discounts under the Financial Assistance Program will only apply to hospital services for which financial assistance was requested and approved, and other hospital services provided within 6 months following such approval, unless otherwise determined by PFS in their sole discretion.

8. MHS will assign a patient account to presumptive eligibility without a Financial Assistance Program application, based on the following predetermined criteria from approved sources:

    a. The patient is documented as being homeless; or

    b. The patient has recently been declared bankrupt by a Federal Bankruptcy Court; or

    c. The patient qualifies for a government-sponsored low-income assistance program.

    Patients who are deemed presumptively eligible to qualify under the Financial Assistance Program shall receive Charity Care for the services provided, to the extent a government program does not reimburse or pay for the services.

D. Billing and Collection Practices

1. If a patient qualifies for discounted payments under the LIFA program, the MHS hospital will negotiate with the patient to create an extended payment plan, taking into consideration the patient's family income and essential living expenses. If the

MHS hospital and the patient are unable to agree on an extended payment plan, the MHS hospital will create a reasonable payment plan in which monthly payments do not exceed 10% of the patient's family income in a month, less essential living expenses. "Essential living expenses" means 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 or spousal support, transportation and auto expenses, including insurance, gas and repairs, installment payments, laundry and cleaning, and other extraordinary expenses. All extended payment plans will be interest free.

2. If a patient qualifying for financial assistance under this Policy makes a payment to an MHS hospital in excess of the amount the patient is determined to be responsible for, the overpayment amount, including interest accrued at a rate of 10% per annum beginning on the date the overpayment is received, shall be promptly refunded to the patient. A MHS hospital is not required to reimburse the patient or pay interest if the amount due is less than $5.00, but will give the patient a credit for the amount due for at least 60 days from the date the amount is due.

3. In the event that a patient qualifying for financial assistance under this Policy fails to make payment in full on their remaining patient liability balance, the MHS hospital, in its sole and exclusive discretion, may use any or all appropriate means to collect the outstanding balance (either directly or through an outside collections agency) while in compliance with California Health and Safety Code 127400 et seq. Prior to commencing any collection activities, the MHS hospital or an outside collections agency seeking to collect the debt on behalf of MHS will provide the patient with a written notice summarizing the patient's rights pursuant to the Hospital Fair Pricing Policies law, the California Rosenthal Fair Debt Collection Practices Act, and the Federal Fair Debt Collection Practices Act.

4. Patients in the process of qualifying for government financial assistance or the MHS Financial Assistance Program will not be assigned to collections prior to 120 days from the date of initial post-discharge billing. If a patient is attempting to qualify for eligibility under the MHS hospital's Financial Assistance Program and is attempting in good faith to settle an outstanding bill with the MHS hospital by negotiating an extended payment plan or by making regular partial payments of a reasonable amount, the MHS hospital shall not send the unpaid bill to any collection agency or other assignee, unless that entity has agreed to comply with guidelines outlined in California Health and Safety Code Section 127400 et seq. Uninsured or low-income patients, who at the sole discretion of the MHS hospital are reasonably cooperating to settle an outstanding hospital bill by making regular and reasonable payments towards their outstanding hospital bill, will not be sent to an outside collection agency if doing so would negatively impact the patient's credit. Patients who communicate that they have an appeal for coverage of services pending will not be forwarded to collections until the final determination of that appeal is made.

5. Any extended payment plan may be declared no longer operative after the patient's failure to make all consecutive payments due during a 90-day period. Before declaring the extended payment plan no longer operative the MHS hospital shall make a reasonable attempt to contact the patient by telephone and to give notice in writing that the extended payment plan may become inoperative, and of the opportunity to renegotiate the extended payment plan. For purposes of this

paragraph, the notice and telephone call to the patient may be made to the last known telephone number and address of the patient. Prior to the extended payment plan being declared inoperative, the MHS hospital shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. The MHS hospital shall not report adverse information to a consumer credit reporting agency or commence a civil action against the patient or responsible party for nonpayment at any time within 150 days after the initial post-discharge billing or prior to the time the extended payment plan is declared to be no longer operative.

6. The MHS hospital will make reasonable efforts (as further described in 26 C.F.R. Section 1.501(r)-6(a)) to determine whether an individual is eligible for financial assistance before engaging, either directly or indirectly, in any of the following collections actions: reporting adverse information about the patient to consumer credit reporting agencies; commencing a civil action against the patient; placing a lien on the patient's property; foreclosing on the patient's real property; or requiring a payment before providing non-emergency care because of outstanding bills for previously provided care. In no event will the MHS hospital use wage garnishments or liens on primary residences as a means of collections. PFS will act as the final authority in determining that the MHS hospital has made reasonable efforts to determine whether a patient qualifies for financial assistance and may therefore engage in the above-described collection actions.

E. Third-Party Providers

Emergency physicians who provide emergency medical services at any MHS hospital are required by law to provide discounts to uninsured patients or patients with high medical costs whose family income is at or below 350% of the FPL.

Physicians providing care at MHS hospitals are independent practitioners and are not employees or agents of MHS. MHS does not provide patient financial assistance for the professional fees charged by physicians and other third-party providers for their services, even if those services were rendered at an MHS hospital. However, to the extent third-party physician providers are contracted to provide medically necessary services at an MHS hospital, such third-party providers may be bound by this Policy. Appendix A, which may be updated from time to time, lists the third-party providers at each MHS hospital obligated to comply with this Policy. This Policy shall not apply to any other third-party providers.

F. Obtaining a Copy of Policy and Appendix A

This Policy and Appendix A are available free of charge online at www.memorialcare.org/guides-tools/financial-assistance. You may also call or visit the Admitting Department of any MHS hospital or contact a Patient Financial Services representative at 877.323.0043 to request a paper copy free of charge.

APPENDIX A

MHS Hospital	Third-Party Providers Covered By MHS FP Policy #236
Long Beach Memorial Medical Center	Anesthesiologists Pathologists Radiologists Emergency Physicians NICU Physicians PICU Physicians Breast Imaging Physicians
Miller Children's Hospital Long Beach	Anesthesiologists Pathologists Radiologists Emergency Physicians NICU Physicians PICU Physicians
Community Hospital Long Beach	Anesthesiologists Pathologists Radiologists Emergency Physicians
Orange Coast Memorial Medical Center	Anesthesiologists Radiologists Pathologists Emergency Physicians NICU Physicians Breast Imaging Physicians Cardiac Surgery Physicians
Saddleback Memorial Medical Center	Pathologists NICU Physicians Emergency Physicians Breast Imaging Physicians

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